SEVERELY EMOTIONALLY DISTURBED YOUTH IN TEXAS

FINANCING AND COORDINATING SERVICES

Lyndon B. Johnson School of Public Affairs
The University of Texas at Austin
Policy Research Project Report

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Severely Emotionally Disturbed Youth in Texas

Financing and Coordinating Services

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Policy Research Project
on Financing and Coordinating Care
for Seriously Disturbed Children
and Adolescents in Texas
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Contents

Foreword xix

Preface xxi

Acknowledgments xxiii

Chapter 1. Introduction 1
- Severely Emotionally Disturbed (SED) Youth in Texas 1
  - Background 2
  - Current Needs 2
  - Do Kids Count? 4
- References 6

Chapter 2. The Texas Education Agency and Special Education Services for SED Students 7
- Scope of Agency 7
- Legislative Context of Services for SED Students 9
  - Funding of PL 94-142 and Chapter 1 Provisions 12
  - Kinds of Services Provided 19
- Organizational Context for SED Student Services 22
- Intra-agency and Interagency Coordination 26
- Possibility of Medicaid Funding 29
- Coordinated Services in Other States 29
- Current Issues of Concern 31
- Conclusions 33
- Appendix 2.1. PL 94-142 Federal Funding Formula 36
- Appendix 2.2. State Education Funding Formula 38
- Appendix 2.3. Instructional Arrangements and Settings 39
- Appendix 2.4. Percentage of School Population Identified as Emotionally Disturbed by Region and County 41
- Appendix 2.5. Maryland System 44
- References 47

Chapter 3. The Texas Department of Human Services 49
- Scope of Agency 49
- Legislative Context of Services for SED Children 49
- Program Services 51
  - Intake and Investigation 51
  - In-Home Services 51
  - Placement Services 51
  - Adoption 55
- Organizational Context for SED Services 56
- Social, Physical, and Emotional Effects of Child Abuse 57
- Conclusions 58
- References 62

Chapter 4. The Mental Health System for Emotionally Disturbed Children in Texas: Community Mental Health Centers and State Facilities 63
- Overview 63
- Child and Adolescent Units of the State Hospital System 66
- Waco Center for Youth 70

Vernon State Hospital Drug Dependent Youth Program 72
Community Mental Health
and Mental Retardation Centers 73
Recommendations 80
Conclusion 87
References 88

Chapter 5. Texas Juvenile Probation Commission 91
Description of the Texas Juvenile Probation Commission 91
General Mandate 91
Administrative Structure 91
Budget 92
Juvenile Probation Programs and Services 95
Texas Juvenile Probation
Commission Services (State Level) 95
Services Provided by Probation
Departments (County Level) 97
The Court System 105
Legislative Context for SED Children's Services
Within the TJPC 106
Current Issues of Concern 107
Issues Determined by Senate Select Committee
on Juvenile Justice 107
Issues Determined by the Runaway Task Force 108
The Overcrowding/Overuse of Detention Centers 110
Other Issues 110
Emotionally Disturbed Children 111
Programs for Youth in the Juvenile Justice System
with Multiple Needs 111
Proyecto Esperanza (Project Hope), Houston 111
Paint Creek Youth Center, Cincinnati 111
Abraxas, Pennsylvania 112
Summary of Model Programs 112
Conclusion 113
References 115

Chapter 6. Texas Youth Commission 117
History 117
Agency Overview 117
Administrative Structure 117
Categories of Service 118
Community-Based Care 120
Funding 121
Organizational Context for SED Children 122
Recidivism 123
Within TYC 123
National Perspective 124
Current Issues of Concern 124
Model Programs 126
Massachusetts 126
Utah 127
Florida 128
Conclusions 129
Appendix 6.1. Texas Youth Commission
Board Members 131
Appendix 6.2. Texas Youth Commission
Agency Organizational Chart 132

Appendix 6.3. Student Characteristics of Commitment to TYC for Period 9/1/88 - 8/31/89 133
Appendix 6.4. Student Characteristics in Population at 8/31/89 134
Appendix 6.5. Commitments/Recommitments by Region and County for Period: 9/1/88 - 8/31/89 135
Appendix 6.6. Cost, Population, and Employees by Institution 136
Appendix 6.7. Program Population for Period 9/1/88 - 8/31/89 137
Appendix 6.8. Mental Health Report of the Texas Youth Commission 138
Appendix 6.9. Percentage Reincarcerated - FY 88 Cohort 143
References 144

Chapter 7. Tapping New Funds through Existing Infrastructure 147
Texas Commission on Alcohol and Drug Abuse 147
- Service Category: Prevention and Intervention 149
- Service Category: Treatment and Rehabilitation 152
- Interagency Coordination 154
- Current Issues of Concern 154
- Data Sources 155

Job Training Partnership Act 155
- Legislative and Organizational Context 155
- Title IIA 156
- Section 123 157
- Interagency Initiatives 158
- Title IIB 158
- Current Issues of Concern 159
- Data Sources 159

Texas Rehabilitation Commission 160
- Description of Programs 160
- Data Sources 165

Texas Early Childhood Intervention (ECI) Program 165
- Funding 165
- Population Served 166
- Services Provided 166
- Eligibility 166
- Results 166
- Relationship to Medicaid 167
- Conclusion 167

Chapter Conclusions 167
Appendix 7.1. Texas Commission on Alcohol and Drug Abuse FY 90 Awards - Youth Prevention/Intervention by City and Recipient 169
Appendix 7.2. FY 90 Awards - Substance Abuse for High Risk Youth by City and Recipient 171
Appendix 7.3. FY 90 Awards - Student Assistance Programs by City and Recipient 174
Appendix 7.4. Texas Commission on Alcohol and Drug Abuse FY 90 Awards - Pilot Primary Prevention by City and Recipient 176
Appendix 7.5. Texas Commission on Alcohol and Drug Abuse

FY 90 Awards - Children of Substance Abusers by City and Recipient 177
Appendix 7.6. Texas Commission on Alcohol and Drug Abuse FY 90 Awards - Youth Treatment by City and Recipient 179
Appendix 7.7. Texas Commission on Alcohol and Drug Abuse Estimated Appropriations and Method of Financing for Fiscal Years 1990 and 1991 181
Appendix 7.8. Service Delivery Area Title IIA Participant Profile as of July 1, 1989 through December 31, 1989 182
Appendix 7.9. Job Training Partnership Act Allotments for Fiscal Years 1988 and 1989 183
Appendix 7.10. Primary Disabilities of TRC Clients Served During FY 1988 184
References 185

Chapter 8. State-Level Coordination of Children's Services 187
Introduction 187
Texas Political System 187
Health and Human Services Agencies 188
Texas Health and Human Services Coordinating Council 188
Impetus for the Health and Human Services Coordinating Council 188
Role of the Health and Human Services Coordinating Council 188
THHSCC Membership, Committees, and Operating Budget 189
Projects and Initiatives 190
General Projects and Activities 190
Residential Contract Care for Children 191
Major Activities Related to Children 194
Memoranda of Understanding 196
Model State Programs 196
Ohio 196
Alaska 199
Conclusions and Recommendations 200
Appendix 8.1. Common Application for Placement of Children in Residential Care 201
Appendix 8.2. Residential Care Cost Analysis Questionnaire 222
Appendix 8.3. Common Definitions for Residential Care 238
Appendix 8.4. Memoranda of Understanding Regarding Services for Children and Youth Mandated by the 70th Legislature 248
Appendix 8.5. Memoranda of Understanding Regarding Services for Children and Youth Mandated by the 71st Legislature 251
References 253

Chapter 9. Private Providers of Services for Severely Emotionally Disturbed Children and Adolescents in Texas 255
- Types of Privately Provided Services 255
  - Residential Services 255
  - Nonresidential Services 262
- Relationship of Private Providers to the State 264
- Recommendations 266
- Appendix 9.1. Private Psychiatric Hospitals with Child/Adolescent Beds Licensed by the Texas Department of Mental Health and Mental Retardation 267
- References 274

Chapter 10. Mental Health Insurance Coverage and its Impact on Financing Care for SED Youth in Texas 277
- Mental Health Coverage and SED Youth 277
  - National Trends in Mental Health Coverage 277
  - Uninsured Youth 278
  - Costs of Insurance Coverage 280
- Oversight Mechanisms Involving Mental Health Care 282
  - Preauthorization 282
  - Utilization Review 283
  - Direct Contracting 283
  - Benefit Design 283
  - Employee Assistance Programs (EAPs) 284
- A Model Program: The Fort Bragg Project 284
- Issues, Concerns, and Problems Specific to Texas 285
- Recommendations 287
- References 288

Chapter 11. The CASSP Model 291
- The CASSP Program 291
  - Background 291
  - The CASSP Strategy 292
  - The CASSP Philosophy 294
- The System of Care 295
  - The Framework 295
  - The Emphasis on Mental Health 295
  - Operational Services 300
  - Balancing Service Capacity 302
- Interagency Coordination 304
  - Fragmentation of Services 304
  - Other Settings 304
  - State Coordination 306
  - Community Collaboration 307
- CASSP: A Model for Texas 308
  - Bringing CASSP to Texas 308
  - Major CASSP Efforts 309
- CASSP-Like Efforts 312
  - Community Resource Coordination Pilot Project 313
  - Intensive Family Intervention 314
  - Case Management 316
- Conclusions 316
- Appendix 11.1. 1989 CASSP Budget Data: State Grants 318

Appendix 11.2. System of Care Framework ... 319
Appendix 11.3. Components of the System of Care ... 320
Appendix 11.4. The Mental Health Component of Care ... 321
Appendix 11.5. Model for a Balanced Community-Based System of Services ... 322
Appendix 11.6. Three-Year Management Plan for CASSP ... 323
References ... 324

Chapter 12. Services in Austin and Travis County ... **329**
Working Definition of SED Children and Adolescents ... 329
Programmic Utilization of the SED Definition ... 330
Profiles of SED Children and Adolescents and Their Families ... 331
Available Services and Programs ... 332
Programs for SED Children and Adolescents ... 333
Program Features ... 334
Characteristics of Agency Personnel ... 334
Interagency Relationships ... 335
Conclusion ... 336
Appendix 12.1. List of Travis County Agencies Interviewed ... 337
Appendix 12.2. Austin-Travis County Agency Survey ... 338

Chapter 13. The Expansion of Medicaid to Cover Services for Severely Emotionally Disturbed Children and Adolescents in Texas ... 347
Preface ... 347
Overview of Medicaid ... 347
Medicaid and Mental Health Services ... 348
Eligibility for Medicaid ... 351
Expanding Medicaid to Cover Mental Health Services ... 355
Medicaid Expansion and SED Children and Adolescents ... 361
Mandatory Medicaid Services ... 361
Available Optional Medicaid Services ... 371
School-Based Services ... 381
The Connecticut School-Based Clinic Program ... 382
Supplementing Versus Supplanting State Funds ... 383
Conclusions ... 384
Appendix 13.1. Mandatory Medicaid Services ... 385
Appendix 13.2. Optional Medicaid Services ... 386
References ... 388

Chapter 14. Conclusions ... 393
Summary of Findings ... 393
The Schools and the Texas Education Agency (TEA) ... 393
The Texas Department of Mental Health and Mental Retardation (TDMHMR) ... 393
The Texas Department of Human Services (TDHS) ... 393
The Texas Juvenile Probation Commission (TJPC) ... 394
The Texas Youth Commission (TYC) ... 394
Other State Agencies ... 394

State Level Coordination 395
Private Health Insurance 395
Expansion of Medicaid 395
State Initiatives 396
TDMHMR 396
TEA/TDMHMR 396
TYC/TDMHMR 396
Interagency Children's Budget Request 396
Developing Programs at the Local Level That Work 397
Funding 402
Where Texas is Today in Its Efforts to Fund 403
Appendix 14.1. Target Population Definition for Children with Serious Emotional Disturbance of the Interagency Children's Mental Health Initiative 404
Appendix 14.2. Service Delivery Plan for Core Service to Children with Serious Emotional Disturbance 405
References 406

List of Tables

Table 2.1. PL 94-142, Part B, Allocations to State Education Agencies for Fiscal Year 1990 14

Table 2.2. Chapter 1 -- Handicapped Allocations to State Education Agencies for Fiscal Year 1990 16

Table 2.3. Number of Emotionally Disturbed Students in Child Counts for PL 94-142 and Chapter 1--Handicapped Funds, 1987 and 1988 18

Table 2.4. Instructional Arrangement by Contract Hour and Funding Weight 21

Table 2.5. Seriously Emotionally Disturbed Students in Texas 1986--1989 23

Table 2.6. State of Texas Special Education Services for Seriously Emotionally Disturbed Students by Age 1986--1989 24

Table 2.7. State of Texas Special Education Services for Seriously Emotionally Disturbed Students by Ethnicity 1986--1989 25

Table 2.8. Emotionally Disturbed Students Served by the TYC School System as Reported in the December 1989 Child Count 28

Table 2.9. State of Texas Special Education Services for Seriously Emotionally Disturbed Students by Instructional Arrangement 1986--1989 30

Table 3.1. Children in TDHS Legal Responsibility in 1987 by Type of Placement 53

Table 3.2. Reimbursement Rates for Substitute Care Effective September 1989 54

Table 4.1. Mental Health Clients Served during FY 1989 64

Table 4.2. Budgets for Child and Adolescent Units for FY 1990 69

Table 4.3. Number of Children and Adolescents Treated at Each State Facility As of October 1990 71

Table 4.4. Operating Budgets of CMHMRCs for Fiscal Year 1990 75

Table 4.5. Operating Budget for Child and Adolescent Mental Health Services 76

Table 4.6. Estimated 1990 LSA Youth Population (Age 0-17) Compared to FY 1989 Persons Served By Community-Based Services 84

Table 4.7. Proposed Budget for Statewide Implementation of a Community-Based, Comprehensive Continuum of Care 86

Table 5.1. Texas Juvenile Probation Budget 93

Table 5.2. Average Costs per Day per Client 94

Table 5.3. Challenge Grant Interim Report for 1989 96

Table 5.4. Juvenile Probation Referral Activity Summary of 1988 Reported Activity Statewide Totals 100

Table 5.5. Juvenile Probation Placements, 1988 102

Table 5.6. Probation Services 104

Table 6.1. TYC Program Population for Period 9/1/87--8/31/88 121

Table 7.1. Projected ECI Program Enrollment from Medicaid Program Expansion 167

Table 8.1. Texas Health and Human Services Agencies 188

Table 8.2. Reimbursement Rates for Substitute Care, Effective September 1989 193

Table 9.1. Comparison of Residential Treatment Centers with Inpatient Hospitalization 260

Table 9.2. Growth in Therapeutic Foster Homes Licensed by the Texas Department of Human Services, 1984--1989 261

Table 12.1. Number of Agencies Providing CASSP-Defined Services and the Number Needing Services that are Unavailable 332

Table 13.1. Medicaid Mental Health Outpatient Options by State 349

Table 13.2. Maximum Adjusted Net Income Levels for AFDC Eligibility by Family Size 353

Table 13.3. 1989 Texas Medically Needy Income and Resources Limits 354

Table 13.4. Comprehensive Service System Components and Relative Medicaid Services 357

Table 13.5. Community MHMR Centers Local Funds During FY 1989 360

Table 13.6. Texas EPSDT Screening Schedule, Periodicity Schedule by Age 364

Table 13.7. Projected Program Expenditures for the Extension of EPSDT Coverage for Chemical Dependency Residential and Outpatient Treatment Services 366

Table 13.8. EPSDT Performance Indicators for Selected States for 1988 370

Table 13.9. Trends in the Growth of Private Psychiatric Hospitals Licensed by TDMHMR. Types and Totals of Psychiatric Beds at Different Points Between 1978 and 1989 374

Table 13.10. Synopsis of Services to be Provided by Texas Rehabilitative Services for Persons With Mental Illness 379

Table 14.1. Texas Children's Mental Health Plan Proposed Budget for FY 1992-1993 Biennium 398

Table 14.2. Total Costs of the Texas Children's Mental Health Plan Proposed Budget for FY 1992-1993 Biennium 401

List of Figures

Figure 2.1. Map of Regional Education Service Centers 8

Figure 3.1. Children in Confirmed Reports of Abuse Needing Services After Investigation vs. Those Actually Served 59

Figure 4.1. Locations of State Hospitals, State Centers, and MHMR Centers 65

Figure 4.2. Texas Local Service Areas (LSAs) 67

Figure 4.3. Mental Health Regions 68

Figure 4.4. Needs of Children and Adolescents with Mental Health Problems in Texas 77

Figure 4.5. FY 1989 vs. Projected Number of Children to be Served by Selected Mental Health Services 81

Figure 5.1. Movement of Juveniles 99

Figure 5.2. Detention Centers 1988 103

Figure 7.1. Continuum of Services Offered by the Texas Rehabilitation Commission 161

Figure 10.1. Health Insurance Coverage in Texas 279

Figure 13.1. Medicaid Beneficiaries by Eligibility Status During FY 1988 352

Figure 13.2. Medicaid Coverage in Texas as of April 1, 1990 356

Figure 13.3. Trends in Private Psychiatric Bed Growth in Texas, Child and Adolescent Beds and Total Beds, Between 1978 and 1989 373

Figure 13.4. Trends in the Growth of Private Psychiatric Hospitals Between 1978 and 1989 in Texas 375

Foreword

The Lyndon B. Johnson School of Public Affairs has established interdisciplinary research on policy problems as the core of its educational program. A major part of this program is the nine-month policy research project, in the course of which two or three faculty members from different disciplines direct the research of ten to twenty graduate students of diverse backgrounds on a policy issue of concern to a government agency. This "client orientation" brings the students face to face with administrators, legislators, and other officials active in the policy process and demonstrates that research in a policy environment demands special talents. It also illuminates the occasional difficulties of relating research findings to the world of political realities.

This report on financing and coordinating care for seriously emotionally disturbed children and adolescents in Texas is the result of a policy research project conducted during the 1989-90 academic year. The project was sponsored and primarily funded by the Hogg Foundation for Mental Health as a parallel activity to their Task Force on Children and Adolescents with Severe Emotional Disturbance. This report examines the public and private mental health systems in Texas and how it identifies, finances, and coordinates care for seriously emotionally disturbed children and adolescents. This volume also discusses the services and resources available to and the agencies involved in the provision of services to SED children and adolescents in Texas. The findings of this report are intended to provide information and insights that will aid mental health professionals, advocates, and legislators in addressing the plight of the mentally ill in Texas.

The curriculum of the LBJ School is intended not only to develop effective public servants but also to produce research that will enlighten and inform those already engaged in the policy process. The project that resulted in this report has helped to accomplish the first task; it is our hope and expectation that the report itself will contribute to the second.

Finally, it should be noted that neither the LBJ School nor The University of Texas at Austin necessarily endorses the views or findings of this study.

Max Sherman
Dean

Preface

This volume is the outcome of a Policy Research Project on financing and coordinating care for severely emotionally disturbed children and adolescents in Texas, which was conducted during the 1989-90 academic year at the LBJ School of Public Affairs at the University of Texas at Austin. In the Spring of 1989, Reymundo Rodriguez and Wayne Holtzman encouraged Dr. Regenia Hicks and I to develop this project to be a parallel activity to the Hogg Foundation for Mental Health's Task Force on Children and Adolescents with Severe Emotional Disturbance which had formed earlier in the year. The primary sources of funding for the entire project were the Hogg Foundation, the University Affiliated Programs for the Developmentally Disabled and the University of Texas. Other funding has been provided by the John Sharpe Fellowship, the Mike Hogg Endowment, and the Wilbur Cohen Professorship at the LBJ School of Public Affairs.

In this study we have attempted to pull together information from a variety of sources in order to better identify and analyze the state agencies and private institutions which affect severely emotionally disturbed children and adolescents in Texas. In particular we have received and analyzed data from myriad of state and local agencies, private providers as well as annual reports and other studies.

We hope that this volume will provide the overview of the public and private institutions involved in the provision of care for severely emotionally disturbed children and adolescents in Texas which is needed for informed policy making.

David C. Warner
December 1990

Acknowledgments

This report is the result of a year-long Policy Research Project at the Lyndon Baines Johnson School of Public Affairs. The project was initiated by Dr. Wayne H. Holtzman, President of the Hogg Foundation for Mental Health, who asked the LBJ School to undertake this project in conjunction with Dr. Regenia Hicks, Coordinator of Children's Programs at the Texas Department of Mental Health and Mental Retardation. The Hogg Foundation provided staff support and primary funding for this project as well as supplementary funding for a conference held in April 1990, which was an offshoot of the project. Additional revenues were provided by the Texas Department of Mental Health and Mental Retardation through the Public Academic Liaison Program. Funding at various points in the project were also provided by the Sharpe and Wilbur Cohen fellowships at the LBJ School and by the University Affiliated Program of the Texas Consortium on Developmental Disabilities. Additional funding for the April conference was also provided by the Child and Adolescent Service Systems Program (CASSP) of the Texas Department of Mental Health and Mental Retardation.

The class benefited in particular from presentations by a wide variety of specialists in the field and from a number of agencies. These speakers included Professor David Austin, U.T. School of Social Work; Dr. Kimberly Hoagwood, Special Education Specialist, Texas Education Agency; Kathy Wooten, Waco Center for Youth, Texas Department of Human Services; Robert Cole, Deputy Director, Mental Health Services Program for Youth, Prudential Insurance Company; Gerry McKimmey, Director, CASSP Program, Texas Department of Mental Health and Mental Retardation; Dr. Ira Iscoe, Professor of Psychology, The University of Texas at Austin; Laurie Romig, Performances Resources, Inc.; Robert McKelvey, M.D., Professor of Psychiatry, Baylor College of Medicine; Tom Olsen, Children's Program Specialist, Texas Health and Human Services Coordinating Council; Kim Carey, M.D., Director of the Children's Psychiatric Services, Austin State Hospital; Dr. Elise Orman, Texas Youth Commission; Carl Pfieffer, M.D., President and Medical Director, Southwest Neuropsychiatric Institute, San Antonio; Debby Gardner, General Counsel, Texas Juvenile Probation Commission; Joe Bowman, former Texas Youth Commission employee and current LBJ student; Deborah Berndt, Mental Health Association of Texas; Michael C. Harrison, Texas Youth Commission; and David Brock, Title IV-e Specialist, Department of Human Services. In addition to taking the time to make a presentation to the class, virtually all of these professionals also provided insights, background data, and analysis to individual members of the class, which often serve as much of the basis of individual chapters. Without their help, this project would have been much more limited.

Individual students visited with Bob Logan, Director of Statistics and Reports, and Keith Rudeseal, Program Specialist, both of the Texas Juvenile Probation Commission. At the Texas Youth Commission, students met with Jimmy Lowell Cannedy, Gary Fuchs, Elise Orman, Murray Smith, and Don Taylor. Thanks are extended to Janet Collins, Director, Case Management Services; Nancy Dittmar, Director, Special Programs; and Rush Russel, Revenue Officer, all of the Texas Department of Mental Health and Mental Retardation; Marla Graham, Director, Children in Need of Services Program, Oklahoma Department of Mental Health; and Augustine Redwine, Analyst, Texas Research League for providing Nick Hoover with information regarding Medicaid and mental health services. At the Texas Education Agency, we wish to thank Richard Craig, Educational Program Director, Division of Special Education Funding and Compliance, Department of Special Education; Kenneth Crow, Director of Interagency Coordination, Department of Special Education; Kimberly Hoagwood, Education Specialist, Division of Program Evaluation; and Tom Patton, Division of Special Education Funding and Compliance, Department of Special Education. Byron Griffin, Superintendent of Schools, Texas Youth Commission; Ruth Haak, Special Education Director, Balcones Special Service Cooperative; Dan Washam, Vocational Rehabilitation Counselor, Texas Rehabilitation Commission; and Richard Yawn, Special Education Director, Windham School System, Texas Department of Criminal Justice were also very helpful to the students who worked on the Texas Education Agency chapter. Thanks are also extended to Irene Alverado, Director of Case Management for Children, Bexar County Community Mental Health Center, and Joanne Brechtol, Director of Case Management, San Antonio State Hospital.

We hope that all of these named and many others who helped in many other ways will find that this report justifies, in part, the time and effort they devoted to helping us understand the issues and needs relating to severely emotionally disturbed youth in Texas.

In conducting the Austin case study, organized by Rosemary Ellmer and Pat Wong, we received a tremendous response from individuals and organizations in Austin and in Travis and Williamson counties. These included Dr. Leslie Moore and Dr. Don Zappone of the Austin Child Guidance Center; Pat Garner of Middle Earth Unlimited; Ronald Stewart Perrett, Janice Brown, and Lynda Sullivan of the Texas Department of Human Services, Region 6; Steve Robinson, Dobbs Rogers, Dennis Campa, and Mark Lovelace of the Travis County Juvenile Court; Betty Phillips of the Austin Independent School District; Donna Samulson of the Early Childhood Intervention Council; Diane Bisig and Cathy Cokerham of CASA; Martha Wynn and Bobbie Matthews of the Settlement Home; Sandra McDaniel of the Brown Schools' Oaks Treatment Center; Diane McDaniel of the Pebble Project; and staff members of both the Austin-Travis County MHMR Center and the Austin State Hospital Adolescent Unit and Child Psychiatric Unit.

Many of our impressions were focused and refined at the April conference entitled Coordinating Care for Severely Emotionally Disturbed Youth in Texas. The keynote speakers at the conference were Dr. Lenore Behar, Chief, North Carolina Mental Health Services; Robert Cole, Deputy Director, Mental Health Services Program for Youth, Prudential Insurance Company; Dr. Jane Knitzer, Children's Defense Fund; and Deborah Berndt, Mental Health Association of Texas. They each provided a uniquely clear and memorable presentation of the issues and potential solutions. The morning panel included Kimberly Hoagwood, Texas Education Agency; Texas State Representative Jack Vowell; Senator Chet Brooks; Regenia Hicks; Carl Volpe, Director, Health Policy Development, Texas Department of Human Resources; Jan Duker, Executive Director, Harris County MHMR; Charlotte Provencher, Child and Adolescent Network, Waco Alliance for the Mentally Ill; and Susan Rogers, Federation of Families in Conroe. These discussants gave varied and continuously interesting perspectives on the problems, constraints, and opportunities in Texas. The afternoon reactor panel consisted of David Austin, Professor of Social Work, The University of Texas at Austin; Don Green, Legislative Budget Board; Dr. Jane Maxwell, Texas Commission on Alcohol and Drug Abuse; Dr. Shirley Sanford, Texas Education Agency; and Ann Stanley, Austin-Travis County Community MHMR. Each provided insight and perspective in critiquing papers presented by the Policy Research Project. The conclusions and proposals of this report were also enriched by comments and insights presented in the five breakout sessions.

We were also fortunate to have been provided with a great deal of help in our visits to particular agencies and institutions. The whole class visited Gardner House in Austin and learned a great deal from a comprehensive and valuable presentation. Similarly, when the class visited Waco Center for Youth, Jack Williams and other staff members were very helpful in describing the whole program to us and Dr. Charles Locklin was very gracious in organizing the afternoon for us.

Chapter 1. Introduction

The mental health needs of youth with severe emotional disturbance (SED) in the United States were largely ignored before Jane Knitzer's book, Unclaimed Children, published in 1982, provided the impetus to identify and better serve these children. Knitzer not only claimed that two-thirds of the emotionally disturbed youth were not identified, but that the current federal funding promoted the more restrictive types of care. The Child and Adolescent Service Systems Program (CASSP), established in 1984, is the unique federally funded partnership with the states which was developed to improve service delivery for this target population.

But even before Unclaimed Children, a lawsuit in 1979 in North Carolina identified this population in what has been called the Willie M. case. The lawsuit was filed on behalf of four plaintiff seriously emotionally disturbed youth against several North Carolina officials for repeated denial of access to treatment or educational programs. North Carolina settled before the case went to court by establishing entitlements for this population. It is important to note that all SED youth in the state were named as members of the suit in addition to the original four. To date, North Carolina is still setting up a system of care to identify and adequately serve the class members and fund the settlement. Although the state does not have specific numbers, it estimates that it will spend $30 million this year to serve approximately 1,200 class members (North Carolina, 1988).

In fact there are many initiatives to improve services, which are woefully inadequate across the nation, for youth with emotional disturbance. There are many stories that can be told by youth and families in Texas about the struggles they have encountered. It is the intent of this report to provide some of the information and options necessary to begin to improve the system in Texas.

SEVERELY EMOTIONALLY DISTURBED (SED) YOUTH IN TEXAS

The quandary faced by the adoptive mother of an eight-year-old boy who has fetal alcohol syndrome, is slightly retarded, and wants to do "nasty things" to his little sister encapsulates the problems we address in this report.

The system won't serve Tommy for a multitude of reasons. Chief among them: He has too many problems. He's too poor. He's too violent. He's acting out sexually. He's too young. Melinda is not abusing him. He hasn't tried to kill himself. He hasn't succeeded in setting the house afire, although he has tried, or in seriously wounding anyone else. If Tommy's family had money or insurance, plenty of hospitals would be willing to help them. If his parents were to beat him, starve him, or sexually abuse him, Dallas County Child Protective Services would take him away. Child Protective Services has 40 slots for residential placements (Wicker, 1990).

Alternatively, his adoptive mother could leave him unsupervised or undermedicated, but she won't and thus there is no protective issue. Similarly the Dallas County Juvenile Department has the biggest budget for children like Tommy, but to be eligible he would have to be at least 10 and commit enough crimes to seem incorrigible (Wicker, 1990).

In Texas it is the rule and not the exception that families seeking help soon discover that service providers themselves are confused as to the availability or location of existing services or simply are unable to provide services due to a critical lack of resources. Limited funds are specifically budgeted in the four major responsible state agencies in Texas to provide services for severely emotionally disturbed youth. Extremely limited coordination between the public and private care providers that serve this population further complicates the problem. In addition, there is no uniform definition for severely emotionally disturbed children and no uniform method of diagnosis. Since the various child-serving agencies have different mandated areas of responsibilities, the issue of coordination to ensure service to "the whole child", is even more important. These are some of the most critical issues that face severely emotionally disturbed youth and their families as they seek help. Long-term and short-term solutions to the problem do exist. These include reallocation of existing resources, increased funding, and collaborative planning and program initiatives.

Background

The Texas Department of Mental Health and Mental Retardation (TDMHMR) as well as other health and human service providers in Texas have traditionally allocated very limited resources to the needs of SED youth in Texas. Until recently, there have not been easy methods of coordinating needed services between the mental health, education, juvenile justice, and human services agencies either at the state or local level. Funding deficits perpetuate a climate of restrictive planning and "turfism." Until 1987, there was no centralized focus at TDMHMR to oversee and advocate for children's services. Children's mental services have generally been underfunded. This problem was made even more severe in recent years when the R. A. J. v. Miller federal court settlement directed TDMHMR to deliver a core of services to the chronically mentally ill adult, but failed to require the same system of services for children and adolescents (TDMHMR, 1987, p. 1).

In 1984, the TDMHMR Task Force on Mental Health Services for Children and Adolescents conducted a needs assessment. This group was composed of hospital and community center staff as well as representatives from public and private agencies serving children. The report relied heavily on the work of a previous task force on child and adolescent mental health services done in 1976 and actually noted that "the same needs, multiplied by eight years of population growth and inattention to mental health services for the youth, are continuing to be unmet today" (TDMHMR, May 1984, p. 6). Although regional differences were strongly indicated by the needs assessment survey, the overwhelmingly demonstrated need was for community-based services.

SED children have primarily been provided treatment under adult mental health services. Traditional outpatient or state hospital treatment approaches have been used. Unfortunately, many children remain in those facilities past the "acute treatment phase" because of the lack of other less restrictive services in the community setting (TDMHMR, 1988, p. 9).

Addressing itself to both the lack of services for SED children and to the lack of coordination among agencies providing those services, the 1984 task force strongly recommended that TDMHMR create a position (preferably at the level of assistant deputy commissioner) responsible for coordinating mental health services for children and encouraged formal coordination at the state level with other agencies serving youth. The report maintained that such coordination, especially case planning and patient tracking, would improve residential services via expansion of the community-based service system. This system would develop alternative services such as crisis intervention, case management, family support, and day treatment with further recommendations. Such steps would require that "there be an incremental increase in the percentage of each community center budget allocated for child and adolescent services, approaching proportionally with the child and adolescent population in need of mental health services" (TDMHMR, 1984, p. 8).

Current Needs

During the past two years, two state surveys have been conducted which further articulate the unmet service needs of Texas youth. Current data, provided in Future Directions for Comprehensive Community-Based Mental Health Services in Texas

(TDMHMR, September 1989, pp. 63-64), show that of the 578,070 children and adults identified as emotionally disturbed, one-half, or 251,336, might be classified as SED. It is estimated that 150,800 of these received services from the private sector with 100,540 dependent on public mental health services. However, approximately 22,000 received such services in FY 1989. The findings of a survey conducted by the Needs and Resources Subcommittee of the Children and Youth Services State Coordinating Committee was published. Service providers were asked to identify the most critical unmet needs of the multiproblem children they serve. The needs most often identified by the respondents were (1) residential treatment for substance abusers; (2) a continuum of care for multiproblem children; (3) closing gaps in educational services; (4) a multiagency evaluation system; (5) an assessment and monitoring network of children's needs and necessary services; and (6) the needs of minority children (HHSCC, February 1989, p. 1).

Considering the need for a continuum of care for multiproblem children, the report discussed the following problems:

1. Mental health services are provided disproportionally to adults, with overall TDMHMR client loads during the first five months of 1988 consisting of 10.6 percent children, 10.7 percent youth, and 78.7 percent adults.

2. Emergency psychiatric care is available only on a limited basis to children whose families do not have insurance and/or financial resources. With approximately 100,000 children and youth in Texas requiring such treatment at any given time, psychiatric support at emergency shelters is also sorely lacking.

3. There is a shortage of emergency shelters providing short-term crisis intervention.

4. Residential psychiatric treatment facilities are often not easily accessible for the families who need the services, and this lack of accessibility also impedes the critical involvement of the family in the treatment process. Although there seems to be "an increased utilization of residential services due to the lack of community-based services," there are only 380 state supported beds.

5. Intermediate care facilities, especially for those children being discharged from state hospitals, are largely unavailable.

6. Therapeutic foster care is seen as the most significant gap. Such care is especially suitable for children being discharged from residential treatment, but such barriers as "low [reimbursement] rates, insufficient training, lack of comprehensive recruitment for foster parents, and minimal respite care and crises intervention systems" are cited for the failure to provide these critical services.

7. "Drastic shortage" of regular foster care.

8. Day treatment programs are "almost non-existent," especially for children in the care of the state. Dallas, Fort Worth, San Antonio, and Houston have programs which serve the general public, but space is limited, and private-sector for-profit programs are available only when third-party reimbursement is available.

9. Intensive in-home services are available only in a small number of pilot programs.

The evaluation, assessment, and monitoring of multiproblem children, so essential to appropriate treatment and placement, was also seen as a critical unmet need by the agencies responding to the survey. Because no statewide criteria exist to diagnose, assess, evaluate, and place children and because a child's evaluation is not often top priority in the placement decision, inappropriate placements are frequently made. Children often experience multiple foster or residential placements extended beyond need, and parents are not consistently involved in the treatment of their children (HHSCC, February 1989, p. 7).

Do Kids Count?

A similar study, commissioned by the Mental Health Association of Texas (MHAT) and funded by the Hogg Foundation, was published in October 1989. Entitled "Do Kids Count? How Texas Serves Children and Adolescents with Severe Emotional Disturbance," this study aimed to determine those barriers in state government that impede the development of an effective service system in Texas (Berndt, October 1989, p. 5). MHAT conducted key-informant surveys with staff from nine state agencies that provide services to children: TDMHMR; the Texas Education Agency (TEA); the Texas Department of Human Services (TDHS); the Texas Youth Council (TYC); the Texas Juvenile Probation Commission (TJPC); the Texas Department of Health (TDH); the Texas Commission on Alcohol and Drug Abuse (TCADA); the Texas Rehabilitation Commission (TRC); and the Texas Employment Commission (TEC). Additionally, to examine the impact of these problems on local communities, mental health providers in Tarrant County and the Lubbock area were interviewed extensively (Berndt, October 1989, p. 6).

For the purposes of the study, MHAT incorporated a major philosophy of the Children and Adolescent Service Systems Program (CASSP), a federally funded program through the National Institute of Mental Health (NIMH). This philosophy supports the belief of MHAT that "children with emotional problems are best cared for, if possible, by their families in their communities" (Berndt, October 1989, p. 6). To facilitate this type of community-based care, a whole range of services must be available locally. In their survey of the various state agencies in Texas, the MHAT found numerous gaps within the proposed CASSP continuum of care, especially for families without insurance (Berndt, October 1989, p. 6). The results of the survey showed that state programs are generally of the most restrictive, inpatient type and that most residential and nonresidential community-based services are purchased by state agencies (especially by TDHS, TYC, and TJPC) for their clients (Berndt, October 1989, p. 6). The components in the CASSP mental health service system which are particularly sought after by those interviewed included early intervention, easily accessible outpatient treatment, home-based services, therapeutic foster and group care, crisis shelters, and reasonably accessible inpatient hospitalization (Berndt, October 1989, pp. 6-12). Based on its survey, MHAT provided an outline of which CASSP services are available in Texas agencies (Appendix F in Do Kids Count?).

The MHAT report identified several other areas of concern. In spite of the legislative mandate of PL 94-142, children with emotional disturbance are clearly being under-identified and underserved in many school districts. Furthermore, certain populations of disturbed children are neglected, especially those who are aggressive or conduct-disordered. Gaps in the community-based services are partially felt by this population because services are prioritized for those considered in most acute need (Berndt, October 1989, p. 12).

The concerns of local communities, as represented by those interviewed in Lubbock and Tarrant County, were even more enlightening. There was general agreement that resources are scarce (again, especially for families without insurance). Waiting lists for services are sometimes months long, and children have to deteriorate to a dangerous level before treatment is sought. Community workers generally lack an understanding of which agencies offer which services and as a result experience considerable frustration.

Furthermore, a lack of crises readiness, a shortage of child psychiatrists, no local funding sources, and geographically inaccessible services were all mentioned as problems faced by the local community face (Berndt, October 1989, pp. 13-15).

In analyzing its findings, MHAT concluded that the major barriers to an effective service system for SED children are: the lack of a comprehensive state plan; the absence of clearly defined roles for state agencies and community service providers; the numerous gaps in community-based services; and insufficient funding for children's services. MHAT's recommendations are largely based on these findings (Berndt, October 1989, p. 15).

It is the purpose of Youth with Severe Emotional Disturbance in Texas: Financing and Coordinating Services to expand and explore the findings and recommendations of CAASP, "Do Kids Count?" and Future Directions for Comprehensive Community-Based Mental Health Services in Texas. This study focuses on existing services as well as gaps in mental health services in Texas.

The next section of the report details the involvement, responsibilities, and future directions of five core state agencies that deal with SED adolescents and children. Separate chapters on the Texas Education Agency, the Texas Department of Human Services, the Texas Department of Mental Health and Mental Retardation, the Texas Youth Commission, and the Juvenile Probation Commission. These chapters identify the scope of the agency, the legislative context for SED children's services, and current issues of concern.

An additional chapter outlines additional state programs such as the Texas Rehabilitation Commission, the Early Childhood Intervention Program, the Job Partnership Training Act, and the Texas Commission for Alcohol and Drug Abuse and addresses the issue of coordination. Separate chapters then describe the private providers of mental health and residential services to seriously emotionally disturbed youth in Texas and the availability of private insurance to cover this population.

Chapter 11 presents the model system of care developed by the Child and Adolescent Service System Program (CASSP) and its implementation in Texas. Chapter 12 summarizes the results of a detailed survey of service providers in Travis County by the members of the class. Although Travis County in general has more services available for this population than most of the state, it was still possible to see gaps in services and limitations in funding.

The final substantive chapter explores ways to fund a model system with the expansion of certain Medicaid funds and other federal funds. The concluding section of the report makes recommendations for better utilization of current resources and restructuring of the current system of care, as well as identifying additional resources needed to ensure that Texas's SED children will not fall through the cracks. In this final chapter, we also identify some current initiatives by the Mental Health Association, the Hogg Foundation, and the principal state agencies which, if funded, will lead to some improvement in care and prospects for these youth.

References

Berndt, Deborah. October 1989. "Do Kids Count? How Texas Serves Children and Adolescents with Severe Emotional Disturbance." Austin: Mental Health Association of Texas.

Health and Human Services Coordinating Council (HHSCC). February 1989. "Needs and Resources Subcommittee Report." In Children and Youth in Texas: A Proposal for Coordinated Services. Austin.

North Carolina Department of Human Resources, Division of Mental Health and Mental Retardation. "The Willie M. Lawsuit: History, Policies, Procedures, and Service Development." Raleigh, North Carolina, Fall 1988.

Texas Department of Mental Health and Mental Retardation (TDMHMR). May 1984. Assessment of Needs: Inventory of Services for Children and Adolescents. Task Force on Mental Health Services for Children and Adolescents Report. Austin.

____________. 1987. Child and Adolescent Service System Program Grant Proposal. Austin.

____________. September 1989. Future Directions for Comprehensive Community-Based Mental Health Services In Texas. Austin.

Wicker, Christine. "In Harm's Way." Dallas Life Magazine, September 30, 1990, pp. 13-14.

Chapter 2. The Texas Education Agency and Special Education Services for SED Students

SCOPE OF AGENCY

The Central Education Agency, composed of the State Board of Education (SBOE) and the Texas Education Agency (TEA), guides and monitors public education in Texas. The SBOE, comprised of 15 elected members representing various regions of the state, is the policy-setting group for Texas public education. The commissioner of education and TEA work closely with the board to aid in the formulation and implementation of education policy (TEA, April 1989).

The Texas Education Agency is located in Austin, Texas, and it serves as the administrative arm of the Central Education Agency. The commissioner of education manages a staff of approximately 1,000 employees. According to its mandate, TEA "provides curriculum assistance, accredits school districts, operates research and information programs, monitors for compliance with federal and state guidelines, and serves as a fiscal agent for distribution of state and federal funds" (TEA, April 1989, p. 2).

Although the SBOE sets policy and TEA helps to implement it, much of the control of the schools remains with the over 1,000 local school districts. There are more than 6,000 public school campuses in Texas. The regional education service centers (ESC) serve as intermediary agencies for TEA and the individual districts. There are 20 ESCs, each representing a varying number of districts (Figure 2.1). The service centers work closely with school districts and TEA in providing technical assistance in such areas as accreditation, curriculum, administrator and other staff training, and the Public Education Information Management System (PEIMS) (TEA, April 1989).

For the 1987-88 school year, revenue for public education budgeted by local school districts exceeded $11.3 billion. Of this amount local school districts provided 51 percent, the state provided approximately 42 percent, and the federal government provided 7 percent. The state average revenue per pupil was $3,513. State funds for public education are distributed through a series of formulas known as the Foundation School Program (FSP). The FSP is "a financing system made up of a series of allotments designed to ensure that each school district can provide instructional programs suitable to meet the minimum educational needs of its students" (TEA, April 1989, p. 11). Most local funds are raised through the local property tax and are used primarily for maintenance, operations, and facility costs. Federal funds are appropriated by Congress for specific programs such as the school lunch program, special education, and services for low-income students.

Approximately half of the expenditures for education in Texas are for instruction. The remaining expenditures include administration, operating costs, and debt service. Instructional expenditure by educational category is divided as follows: 71.5 percent for regular education; 10.6 percent for special education; 10.2 percent for compensatory education; 4.7 percent for vocational eduction; 1.9 percent for bilingual education; and 1.3 percent for gifted and talented programs (TEA, April 1989, p. 14).

The Department of Special Education within the Texas Education Agency is responsible for the monitoring and program duties required by law for all the special education programs in the public schools in Texas. The Department of Special Education is divided into four divisions: Special Education Funding and Compliance, with a staff of 18 consultants; Special Education Programs, with a staff of 19 consultants; Services for the Deaf, with 3 consultants; and Interagency Coordination, with 3 consultants.[1]

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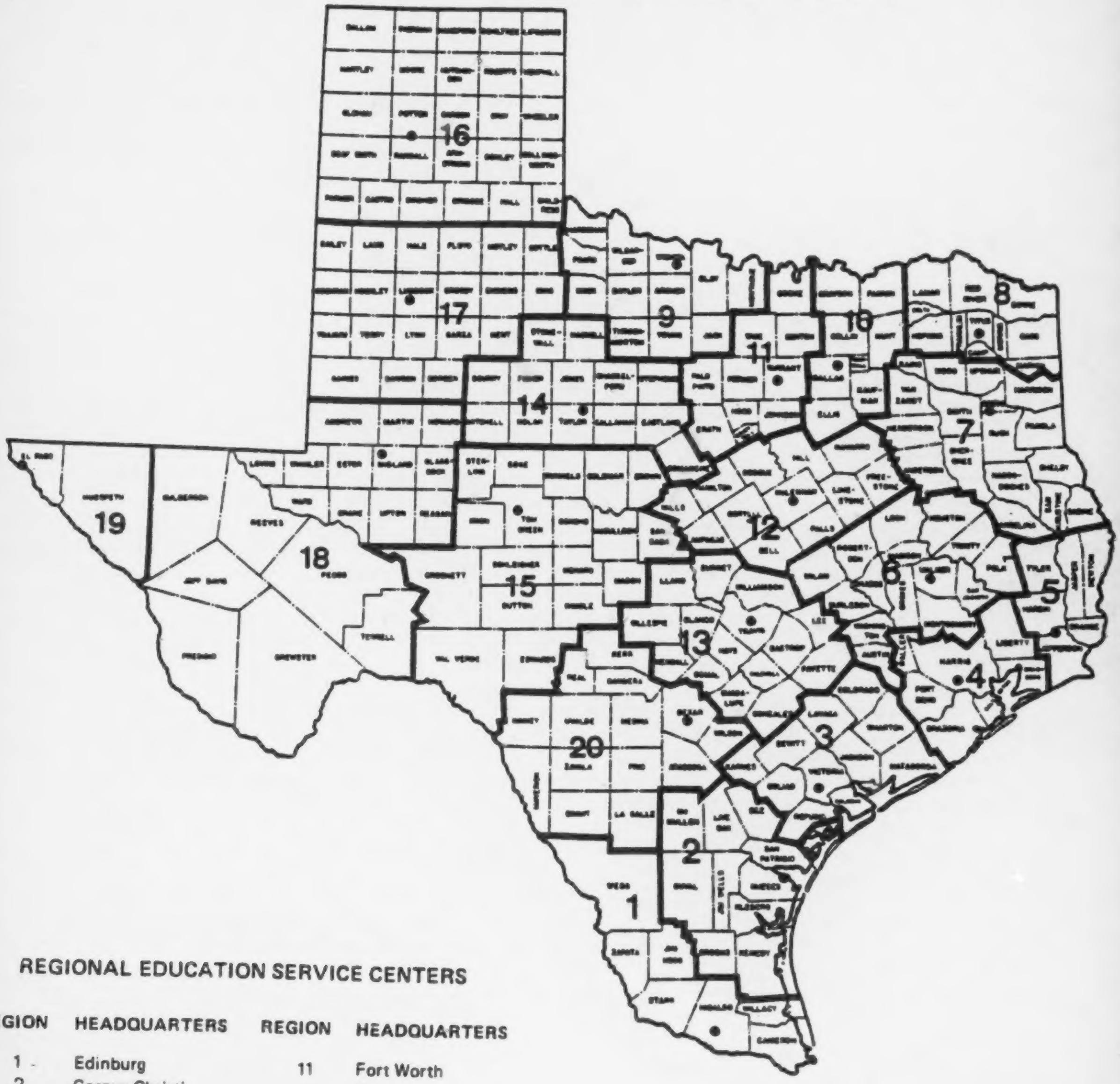
[1] Consultants are persons who specialize in a particular program area. They offer technical assistance to the districts.

Figure 2.1. Map of Regional Education Service Centers



REGIONAL EDUCATION SERVICE CENTERS

REGION	HEADQUARTERS	REGION	HEADQUARTERS
1	Edinburg	11	Fort Worth
2	Corpus Christi	12	Waco
3	Victoria	13	Austin
4	Houston	14	Abilene
5	Beaumont	15	San Angelo
6	Huntsville	16	Amarillo
7	Kilgore	17	Lubbock
8	Mount Pleasant	18	Midland
9	Wichita Falls	19	El Paso
10	Richardson	20	San Antonio

Source: TEA, Division of Educational Service Centers. 1990 (Mimeograph.)

The Division of Special Education Funding and Compliance is responsible for the legal and fiscal aspects of special education programs. Most local district monitoring to determine compliance with the state and federal laws and rules is performed by this division. The division also processes documents related to state and federal funds for special education and administers the comprehensive statewide program for visually handicapped students.

The Division of Special Education Programs is responsible for providing technical assistance to school districts, education service centers, and parents concerning all aspects of special education. These areas of assistance are referral, assessment, individual educational plan (IEP), development, programming, and placement. The division also performs some monitoring and helps interpret TEA rules or current legislation.

The Division of Services for the Deaf is responsible for operating TEA's Regional Day School Program for the Deaf. Five regional offices are maintained around Texas to provide technical assistance to districts with regional day school programs for the deaf. The division also monitors and reviews the programs of these districts.

The Division of Interagency Coordination, formerly known as the Division for Interagency Coordination, acts as a coordinator between the school districts and the other public and private agencies as well as other governmental groups offering educational services for the handicapped. Other agencies providing educational support services include the Texas Department of Mental Health and Mental Retardation (TDMHMR), the Texas Rehabilitation Commission (TRC), the Texas Department of Criminal Justice (TDCJ), the Texas Youth Council (TYC), the Texas Department of Human Services (TDHS), and the Texas Department of Health (TDH). The Texas Education Agency is the only state agency with a policy-level office devoted solely to interagency coordination (Crow, Interview, November 10, 1989).

LEGISLATIVE CONTEXT OF SERVICES FOR SED STUDENTS

During the first half of this century, mentally and physically handicapped children were educated in private schools or state schools or were simply ignored because their contribution to society was believed to be minimal at best. Through litigation, congressional action, and the attempt by some states and local school districts to improve special education, handicapped children began slowly to be brought into the mainstream of education. It was not until 1975 that a cohesive federal plan for the education of handicapped children was established with the passage of Public Law 94-142, also known as the Education for All Handicapped Children Act. PL 94-142 defines the guidelines by which public education for handicapped children between the ages of 3 and 21 is to be implemented by each state. The identification of handicapped students, referral for assessment, the assessment process, the resulting individualized education program (IEP),[2] and ultimately placement into a particular special education instructional arrangement is made possible by PL 94-142.

Congress explicitly stated its intent to increase the quality of education for the handicapped by establishing the four purposes of the act. Listed in Section 601(c) of the Education for All Handicapped Children Act, these four purposes are (1) to assure that all handicapped children receive a free appropriate public education; (2) to assure that the rights of handicapped children and their parents or guardians are protected; (3) to assist states and localities to provide for the education of all handicapped children; and (4) to assess and assure the effectiveness of efforts to educate handicapped children (U.S. Department of Education, 1985).

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[2] Individualized education program (IEP) as used in PL 94-142 is synonymous with individual educational plan (IEP) as used in the Texas Administrative Code.

The definition of an emotionally disturbed child depends on the source of that definition. The definitions of "handicapped" and of "seriously emotionally disturbed" according to PL 94-142 are found in Title 34 of the Code of Federal Regulations. The code defines "handicapped children" as "those children evaluated as being mentally retarded, hard of hearing, deaf, speech impaired, visually handicapped, seriously emotionally disturbed, orthopedically impaired, other health impaired, deaf-blind, multihandicapped, or as having specific learning disabilities, who because of those impairments need special education and related services" (34 CFR, Reg. 300.5[a]). "Seriously emotionally disturbed" is defined as "a condition exhibiting one or more of the following characteristics over a long period of time and to a marked degree, which adversely affects educational performance: (1) an inability to learn which cannot be explained by intellectual, sensory, or health factors; (2) an inability to build or maintain satisfactory interpersonal relationships with peers and teachers; (3) inappropriate types of behavior or feelings under normal circumstances; (4) a general pervasive mood of unhappiness or depression; or (5) a tendency to develop physical symptoms or fears associated with personal or school problems." The definition includes children who are schizophrenic.but not children "who are socially maladjusted, unless it is determined that they are seriously emotionally disturbed" (34 CFR Reg. 300.5[b][8]).

Texas state law defines emotionally disturbed students, rather than seriously emotionally disturbed students, as follows: "Emotionally disturbed students means students whose emotional condition is psychologically or psychiatrically determined to be such that they cannot be adequately and safely educated in the regular classes of the public schools without the provision of special services" (Tex. Ed. Code, Sec. 21.503[a]). No distinction is made between serious emotional disturbance and emotional disturbance in either state or federal law; the two are used synonymously in the education system.

State Board of Education regulations, as expressed through the Texas Administrative Code, likewise defines emotionally disturbed students rather than seriously emotionally disturbed students. An emotinally disturbed student is one "who has been evaluated by a licensed or certified psychologist, psychiatrist, or by a psychological associate under the direct supervision of a licensed or certified psychologist who determines that the student meets the criteria as defined in 34 Code of Federal Regulations 300.5(b)(8) relating to Handicapped Children." The SBOE regulation continues by specifying that the report of individual assessment made by the evaluating professional must include "(1) the type and severity of the emotional disturbance; (2) the functional implications of the disability for situations involving instructions; (3) the degree to which in-school and out-of-school behavior reflects symptoms consistent with the diagnosis and identification of behavior considered to be a direct result of the emotional handicap; and (4) recommendations for behavioral management in the educational setting" (Tex. Admin. Code, Title 19, part II, Ch. 89 [g]).

Three provisions were established in PL 94-142 to ensure that all handicapped children receive a free and appropriate public education. First, a system of funding was established that would enable local school districts to provide adequate services to properly educate handicapped youths. The second provision was the designation of the Least Restrictive Environment (LRE). The third provision was the individualized educational program.

Identification, assessment, and placement procedures for handicapped children for special education programs are prescribed by PL 94-142. One way of explaining how handicapped children access special education programs is by explaining the identification and assessment process in the Texas public school system.

State Board of Education rules stipulate the procedure for referring a student for assessment of a serious emotional disturbance. School professionals must submit documentation concerning "the student's current educational status, previous educational interventions provided or considered for the student and the results of such efforts, updated health history evaluations, and information provided or reported by the parents" (Tex. Admin. Code, Title 19, Ch. 89.232 [b][3]). Previous educational interventions include modifications for the student's instructional program, compensatory education, and school counseling. Almost all referrals of children for special education services are initiated by either teachers or parents (Craig, Interview, September 26, 1989).

After a referral is made, both federal law (34 CFR 300.5[b][8]) and state board rules (Ch.89.211 [g][1]) require that assessment (testing) for a diagnosis of seriously emotionally disturbed be conducted by licensed or certified psychologists, psychiatrists, or psychological associates under the direct supervision of licensed or certified psychologists. The actual diagnostic statement of seriously emotionally disturbed can be made only by a licensed or certified psychologist or psychiatrist.

By itself, the diagnostic statement of seriously emotionally disturbed is not enough to qualify a student for special education services. A student could have a serious emotional disturbance, but if this problem does not affect educational performance, then special education is not required. For example, a child may be depressed and emotionally disturbed yet still receive above-average grades. If this were the case, the child would not qualify for special education due to emotional disturbance. However, an emotionally disturbed child will usually have difficulty learning (Haak, Interview, December 6, 1989).

Federal regulations specify that the evaluation of a handicapping condition be conducted by a multidisciplinary team of persons; one of these persons must be a teacher or specialist in the area of the suspected disability (34 CFR 300.532[e]). The multidisciplinary team performs a Comprehensive Individual Assessment (CIA) on each child referred to special education in order to determine if that child is eligible for special education. The results of the assessment, in written form, are reviewed by the Admission, Review, and Dismissal (ARD) Committee to determine eligibility for services and to design the educational program. The ARD committee is composed of one or both parents, a teacher (either the regular classroom teacher or a special education teacher), a representative of the school district's administration (usually the building principal), a representative from the special education assessment team, and, when appropriate, the student.

The ARD Committee meets initially to determine whether the child is qualified for special education based on the finding of the assessment report (this includes the diagnostic statement); if it is determined that the child does qualify for special education, then the committee decides on the IEP for this child. After the IEP is determined, the ARD Committee must meet at least annually to review the IEP.

The IEP is defined by both federal regulations and SBOE rules (34 CFR 300.346; Tex. Admin. Code, Title 19, Ch. 89.223). The IEP specifies the type of instructional arrangement (the nature of the special education instruction and the amount of time spent in special education as opposed to regular education) as well as the criteria and schedule for evaluating the student's progress. The IEP also includes provisions for related services such as psychological counseling and physical therapy if these services are deemed necessary for a student to benefit educationally.[3]

It is important to note that parents' rights are of utmost consideration throughout the referral and assessment process. Parental consent is required before the assessment process can begin and then again for the initial placement of a handicapped child in special education. Eight or ten years ago, parents were more strongly opposed to having their children assessed for emotional disturbance, but within the last two or three years, there has been a growing acknowledgment of emotional disturbance within families. This reversal in attitudes is attributable to the fact that more families are having to deal with seriously emotionally disturbed children; therefore, the diagnosis is less of a stigma (Haak, Interview, December 6, 1989).

PL 94-142 is a comprehensive and impressive piece of legislation on paper. Unfortunately, in reality it does not and cannot accomplish all that it has set out to accomplish. Some of the reasons for its problems are lack of funding by the federal and state governments, lack of instruction for localities on how to provide the best services, and lack of professionals in rural areas to evaluate handicapped students.

Funding of PL 94-142 and Chapter 1 Provisions

Federal funds for special education originate from two sources: (1) entitlements under the "Chapter 1--Handicapped" provisions in the Education Consolidation and Improvement Act (ECIA) and (2) entitlements under Part B of PL 94-142. Chapter 1 funds go specifically to assist state education agencies with programs that meet the special education needs of handicapped children from birth to 21 years of age in state-operated or state-supported facilities.[4] In addition, Chapter 1 funds may be made available by those state education agencies, under certain conditions, for handicapped children who have left a state agency program and are enrolled in a local school district program (PL 100-297, amendment to ECIA, Sec. 1225). The purpose of allowing the local education agencies to receive Chapter 1 funds for students who transfer from a state-operated or state-supported facility is "to encourage the placement of handicapped children in local schools rather than in institutional settings" (U.S. Code Congressional and Administrative News, 1989, p. 123).

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[3] 34 CFR 300.13[a] defines "related services" as "transportation and such developmental, corrective, and other supportive services as are required to assist a handicapped child to benefit from special education, and includes speech pathology and audiology, psychological services, physical and occupational therapy, recreation, early identification and assessment of disabilities in children, counseling services, and medical services for diagnostic or evaluation purposes." The term also includes school health services, social work services in schools, and parent counseling and training.

[4] A state-operated school is a school or program which is administered directly by a state agency. A state-supported school is a school or program operated under contract or other arrangement with a state agency (34 CFR 302.3).

Funds originating from Chapter 1[5] and PL 94-142 are distributed to the state educational agencies in block grants[6] for the purpose of supplementing state and local funds in educating handicapped children. Both Chapter 1 and PL 94-142 funds are based on the December 1 state child counts of the number of students in special education. Although some handicapped students could qualify to be counted for both Chapter 1 and PL 94-142 , duplication of funding is prohibited. Explicit cross-referenced wording in both PL 100-297 and PL 94-142 guard against this funding duplication. Tables 2.1 and 2.2 show the state-by-state allotments of PL 94-142 and Chapter 1 funds for FY 1990.

If a child is eligible for funding under both sources, a district is allowed to choose under which act it prefers to count the child. Chapter 1 funds average approximately $501 per child, whereas PL 94-142 funds average approximately $238 per child. Even though more money is provided by Chapter 1 grants, Chapter 1 child counts in Texas are almost always lower than PL 94-142 child counts for two reasons. First, there are fewer children who are eligible under Chapter 1, and, second, the record-keeping cost associated with a grant generated by only a handful of students may not be cost efficient for the eligible district (Craig, Interview, December 8, 1989). Table 2.3 shows the number of students in Texas counted under either PL 94-142 or Chapter 1 for 1987 and 1988.

As previously mentioned, these federal funds are meant solely as a supplement to state and local funds, not as a substitute (34 CFR 300.180-182; PL 100-297, Sec. 1222). In order to receive PL 94-142 funds, a local school district must spend "at least an amount of state and local funds equal to the average amount of funds spent on all students in the district" (34 CFR 300.183).[7]

In order for local school districts to receive federal funds, their application for funding must be approved by TEA. If a school district is not eligible for at least $7,500 dollars of PL 94-142 funds, that school district must form a cooperative arrangement with either its regional education service center or another special education program in order to receive its federal entitlement (TEA, August 1989, p. 13).

Currently TEA allocates federal entitlement money to districts on a second-year funding basis--when the finalized federal funding schedule is available but Texas is in the process of moving to first-year funding, which means that districts will receive allocations of federal funds in the first year that these funds become available rather than in the second year. For the 1988-89 school year, the amount of federal special education block grants allocated to Texas school districts totaled $89,493,443, excluding discretionary money. Of this total, $74,969,000 is derived from the PL 94-142 part B formula money, $9,075,371 is PL 94-142 part B preschool money, $3,739,921 is Chapter 1 money, and $1,709,151 is Chapter 1--Deaf money (Craig, Letter, March 19, 1990).

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[5] The Chapter 1 grant that a state (other than Puerto Rico or the U.S. territories) may receive is "equal to the number of eligible children multiplied by 40 percent of the State average expenditure per pupil (but no more than 120 percent, or less than 80 percent, of the national average expenditure per pupil" (U.S. Code Congressional and Administrative News, 1989, p. 213).

[6] These federal grants are provided in one block, but they are categorical in nature, to be used for specific purposes as dictated in federal statute.

[7] This stipulation ensures that children served with these funds have at least the same average amount spent on them from other sources as do the children in the school district taken as a whole.

Table 2.1. PL 94-142, Part B, Allocations to State Education Agencies for Fiscal Year 1990

State	Number of Children	Total Allocation
Alabama	102,545	$ 34,176,741
Alaska	12,231	4,076,651
Arizona	53,673	17,889,468
Arkansas	44,210	14,735,405
California	427,846	142,603,125
Colorado	48,355	16,116,954
Connecticut	60,2601	20,084,947
Delaware	10,376	3,458,371
District of Columbia	2,974	991,248
Florida	199,996	66,659,626
Georgia	90,985	30,325,737
Hawaii	11,801	3,933,330
Idaho	19,271	6,423,117
Illinois	205,514	68,498,802
Indiana	100,521	33,504,132
Iowa	56,196	18,730,396
Kansas	41,074	13,690,161
Kentucky	73,109	24,367,581
Louisiana	65,168	21,720,807
Maine	27,080	9,025,894
Maryland	87,523	29,171,836
Massachuesetts	133,796	44,594,849
Michigan	149,706	49,897,728
Minnesota	81,119	27,037,352
Mississippi	58,406	19,467,000
Missouri	98,136	32,709,200
Montana	15,068	5,022,237
Nebraska	31,159	10,385,444
Nevada	15,471	5,156,559
New Hampshire	16,653	5,550,525
New Jersey	168,794	56,259,860
New Mexico	31,339	10,445,439
New York	259,333	86,436,933
North Carolina	111,332	37,107,490
North Dakota	12,012	$ 4,003,657

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Table 2.1 (Continued). PL 94,142, Part B, Allocations to State Education Agencies for Fiscal Year 1990

State	Number of Children	Total Allocation
Ohio	190,928	$ 63,637,219
Oklahoma	63,288	21,094,194
Oregon	45,539	15,178,367
Pennsylvania	190,454	63,479,232
Rhode Island	19,237	6,411,784
South Carolina	75,176	25,055,522
South Dakota	13,931	4,643,269
Tennessee	100,747	33,579,459
Texas	310,592	103,521,804
Utah	41,267	13,754,489
Vermont	10,181	3,393,376
Virginia	114,887	38,292,388
Washington	73,097	24,363,581
West Virginia	43,474	14,490,093
Wisconsin	76,565	25,519,482
Wyoming	9,716	3,236,389
BIA	--	18,215,421
Puerto Rico	35,268	11,754,994
Guam	--	4,480,348
American Somoa	--	1,560,722
Northern Marianas	--	761,986
Virgin Islands	--	4,146,094
Palau	--	616,196
National Totals	4,337,376	$ 1,475,449,000

Source: US Department of Education, Office of Special Education and Rehabilitative Services, Office of Special Education Programs. 1990. (Mimeograph.)

Table 2.2. Chapter 1 -- Handicapped Allocations to State Education Agencies for Fiscal Year 1990

State	Number of Children	Total Allocation
Alabama	651	$ 280,879
Alaska	2,878	1,834,423
Arizona	1,483	702,248
Arkansas	3,449	1,465,584
California	3,233	1,612,111
Colorado	4,750	2,660,547
Connecticut	4,645	2,960,701
Delaware	3,532	2,251,280
District of Columbia	4,239	2,701,918
Florida	7,929	4,014,664
Georgia	3,080	1,381,983
Hawaii	454	230,558
Idaho	199	84,561
Illinois	40,915	22,389,380
Indiana	9,324	4,453,594
Iowa	1,367	699,839
Kansas	2,634	1,393,661
Kentucky	3,517	1,494,479
Louisiana	4,197	1,783,432
Maine	1,187	611,271
Maryland	1,974	1,258,218
Massachuesetts	16,713	10,652,756
Michigan	13,832	8,009,434
Minnesota	446	251,035
Mississippi	894	379,888
Missouri	2,529	1,178,476
Montana	762	428,376
Nebraska	299	150,407
Nevada	599	289,153
New Hampshire	1,037	545,835
New Jersey	6,194	3,948,026
New Mexico	266	125,449
New York	35,342	22,526,821
North Carolina	2,776	1,179,606
North Dakota	717	328,897

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Table 2.2 (Continued). Chapter 1 -- Handicapped Allocations to State Education Agencies for Fiscal Year 1990

State	Number of Children	Total Allocation
Ohio	9,599	4,699,538
Oklahoma	959	407,508
Oregon	8,270	4,811,447
Pennsylvania	23,152	14,270,285
Rhode Island	935	595,965
South Carolina	975	419,016
South Dakota	503	213,740
Tennessee	1,460	620,398
Texas	13,622	6,173,818
Utah	2,200	934,846
Vermont	2,799	1,637,663
Virginia	1,685	856,397
Washington	3,940	2,090,618
West Virginia	1,560	787,729
Wisconsin	3,178	1,934,416
Wyoming	1,219	776,985
Puerto Rico	1,081	259,192
Guam	372	160,330
American Somoa	63	26,771
Northern Marianas	423	179,745
Virgin Islands	164	84,073
National Totals	**266,212**	**$ 148,200,000**

Source: US Department of Education, Office of Special Education and Rehabilitative Services, Office of Special Education Programs. 1990. (Mimeograph.)

Table 2.3. Number of Emotionally Disturbed Students in Child Counts for PL 94-142 and Chapter 1--Handicapped Funds, 1987 and 1988

	Ages	Number of ED Children
EHA-B		
December 1987	6-21	22,716
December 1988	6-21	23,485
Chapter 1, Handicapped		
October 1987	6-20	227
December 1988	6-21	456

Source: TEA, Division of Special Education Funding and Compliance, Austin.

Federal law stipulates that no more than 5 percent of the total grant, or $350,000 dollars (whichever is greater), can be used for administrative purposes. No more than 20 percent can be reserved by the state for use in the discretionary fund. Discretionary money is used to fund special education pilot programs, the regional education service centers, and, in some cases, private residential placements. No less than 75 percent is distributed to the local school districts.

Federal PL 94-142 funds are based on the number of handicapped students between the ages of 3 and 21 in a state or territory. The states aggregate their child counts and then present them to the Department of Education. The Department of Education calculates each state's PL 94-142 grant using a national per pupil cost and the aggregated child counts (Appendix 2.1 explains the federal formula). Upon receiving the PL 94-142 grant, TEA distributes this money to the districts.

State funding for special education is set according to a prescribed formula which incorporates contact hours (set by TEA) and instructional arrangement weights (set by the legislature).[8] The exact formula incorporates additional information, but these are the pertinent components. Appendix 2.2 contains a working example of the formula for calculating state special education allotments.

Officially, TEA requires that attendance be taken twice a year, in the fall and in the spring. The overall district attendance figures that represent the best four out of eight weeks of a school year are the figures that are used to compute the district's special education allocation (Craig, Interview, September 26, 1989).

Kinds of Services Provided

Local school districts are required to comply with the provisions of PL 94-142 in providing free and appropriate education to all handicapped children between the ages of 3 and 21. Assessing and providing the appropriate special education program for a school-age child is a task for which many school districts lack adequate resources.

The placement of each child into a particular instructional arrangement is provided by the IEP. Federal regulation requires that each public agency shall ensure that the educational placement of each handicapped child is determined at least annually, is based on his or her individualized education program, and is as close as possible to the child's home. The regulation further specifies that various alternative placements must be available to the extent necessary to implement the individualized education program for each handicapped child. Unless the ARD Committee determines that some alternative instructional arrangement is most appropriate, the child must be educated in the school which he or she would attend if not handicapped, that is, in the least restrictive environment (34 CFR Reg. 300.552[a]).

The SBOE rules identify 14 instructional arrangements or placements (Tex. Admin. Code, Ch.89.242[c]). Appendix 2.3 describes each of these instructional arrangements. The instructional arrangement into which a special education student is placed is not based on the type of handicapping condition. Rather, the instructional arrangement is based on one of two criteria: either the number of hours spent in special education instruction or the location of the instruction. For example, if an IEP includes the resource room, the child will spend less than 50 percent of the day in special education in a school district setting. However, if the severity of the handicap requires treatment in a hospital, the child will be placed in a hospital arrangement and receive anywhere from one to six hours of special education in that hospital setting.

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[8] Senate Bill 1019, passed by the 71st Legislature, changed this procedure. Starting in school year 1991-92, the instructional arrangements and weights for the instructional arrangements will be set by the SBOE.

The 14 special education instructional arrangements with their respective number of contact hours (generally regarded as time spent in contact with a special education teacher) and state funding weight are shown in Table 2.4.

As might be expected, the type of instructional arrangement and the number of aggregate contact hours that a child spends in special education translates into the amount of state special education money a district receives. If a student is in special education for more than four contact hours a day, then that child can generally be counted as a full-time-equivalent special education student. The more full-time students in special education arrangements in a school district, the more state money the district can receive, assuming all regulations are met.

Residential Placement is one of the most controversial of all the instructional arrangements. The high cost associated with this arrangement is one reason for the controversy. Currently the cost of a private residential placement, not including the cost of education and related services costs, ranges from $16 per day for a "primary level of care" facility to $147 per day for a "severe level of care" facility. One final category, which includes psychiatric hospitals, is exempt from the established rate schedule. This "exempt" category has resulted in residential placements costing in excess of $200,000, in some instances (Craig, Interview, December 8, 1989).

When the ARD Committee decides that residential placement is the least restrictive environment for an individual, then residential placement is not an exception to the requirement of educating handicapped students in the least restrictive environment. Furthermore, given certain circumstances, the students in this arrangement can actually be classified in other instructional arrangements. For example, in the scenario of five students residing at Shoal Creek Hospital in Austin (three being from outside the Austin school district and two being from the Austin school district), the three residents from other school districts will be counted as Residential Placements whereas the two Austin residents will be counted in the Hospital Class arrangement if they receive their education at the residential facility.

Another scenario may help to illustrate the variety of instructional arrangements that can exist for students living at a residential facility. Of the two Austin students mentioned previously, if one attends class at the residential facility, he or she is considered to be in a Hospital Class arrangement. If the second Austin student attends class at a local high school, then that student would be in a Resource Room instructional arrangement (Craig, Interview, December 8, 1989).

The SBOE rules require that each school district set aside 25 percent of its PL 94-142 funds for residential placements. If no residential placements occur, then the money can be rebudgeted in April of each year for use elsewhere in the special education program. If a school district does place a student residentially, then it is obligated to use the 25 percent from PL 94-142 toward the cost of placement; the rest of the cost can be made up from discretionary funds held by TEA. Requiring school districts to set aside 25 percent of their federal funds for residential care has helped reduce the number of residential placements. A few years ago, there were 400 students placed residentially; today there are approximately 150 students receiving special education under the Residential Placement arrangement (Craig, Interview, December 8, 1989).

The Joint TEA/TDMHMR Task Force on Emotional Disturbance conducted an evaluation of the costs and outcomes of 114 children and adolescents with serious emotional disturbance who had been placed by school districts in residential treatment

Table 2.4. Instructional Arrangement by Contract Hour and Funding Weight

Instructional Arrangment	Number of Contract Hours	Funding Weight
Resource Room*	2.00	2.70
Self-Contained, Mild and Moderate, Regular Campus	3.25	2.30
Self-Contained, Severe, Regular Campus	5.50	3.50
Self-Contained Seperate Campus	5.50	2.70
Multidistrict Class	4.25	3.50
Vocational Adjustment Class	5.50	2.30
Community Class	4.25	3.50
Self-Contained, Pregnant**	4.00	2.00
Homebound	1.00	5.00
Hospital Class	4.50	5.00
Speech Therapy	.25	7.11
State School Students	5.50	5.00
Residential Care and Treatment Facility (out-of-district)	5.50	5.00
Mainstream	N/A	N/A

Sources: TEA, Texas Daily Register of Pupil Attendance; SB 1019, 71st Texas Legislature

* Less than 50 percent of the student's instructional day in special education classes comprises Resource Room; 50 percent or more of the student's instructional day in special eduction classes with more than 2 regular classes comprises the Mild and Moderate definitions; 50 percent or more of the student's instructional day in special education classes with 2 or less regular classes comprises the Severe definition (TEA, Texas Daily Register of Pupil Attendance, p. 8).

** PL 94-142 does not classify pregnancy as a handicapping condition. This is another example of the uniqueness of Texas.

facilities for educational purposes. The draft of the report of this survey, due out in January of 1991, found that long-term residential placement did not result in positive outcomes for students in most cases.

Econometric analyses indicated a total annual cost to the state of $5 million, or $80,000 per youth per length of stay. Outcome analyses revealed that 63 percent of the youth either made no progress, had been discharged with a negative outcome, or could not be located. In only 25 percent of these cases did the youth have a positive discharge status, measured by their return to school, return to home, or placement into a vocational training program. Additionally, negative outcomes were associated with longer lengths of stay. The availability of community-based services for student and family was the single most likely reason reported by special education directors for positive discharge status (TEA, October 1990).

ORGANIZATIONAL CONTEXT FOR SED STUDENT SERVICES

The total number of children in Texas categorized as SED students in the 1988-89 school year was 36,840 (Table 2.5). The total special education population during the same year was 411,783.

The majority of the SED children in the education system fall between the ages of 12 and 17 (Table 2.6). The ethnic breakdown shows that over half of the SED children are Caucasian, while the black and Hispanic children make up 15 and 20 percent respectively (Table 2.7). These percentages correspond to the percentages of white, black, and Hispanic students in public education in Texas (Crow, Interview, November 10, 1989).

According to federal estimates, 10 to 12 percent of the children in the United States may be eligible for special education, and 3 to 4 percent eligible for SED programs. If these national estimates were applicable, between 65,100 and 99,080 children in Texas could be eligible for SED programs in special education. The Joint Task Force on Emotional Disturbance of the Texas Education Agency and the Texas Department of Mental Health and Mental Retardation has set the following goals for Texas in order to increase the assessments of potentially SED children:

> Any district of more than 200 students which does not identify at least 1% of its total population as emotionally disturbed needs to provide evidence that it has investigated through professionally adequate assessment a number of potentially emotionally disturbed students equal to 1%. This standard should be set for 1990; a standard of 2% should be set for 1995. In addition, such a district should be able to show that it is identifying and serving at least some children as emotionally disturbed (TEA, June 1989, p. 110).

Currently there is no consistent system of identification for ED children in Texas. One-third of the school districts of the state identify no child as emotionally disturbed. Another third of the school districts identify fewer than one-half of one percent (0.05 percent). Of the 36,840 children identified in 1988-89 as emotionally disturbed, 623 dropped out of school during that year, further reducing the number presumed to have received appropriate services for their disabilities (TEA, June 1989).

The state of Texas is divided administratively into 20 geographic regions for educational purposes by the Texas Legislature. Only Region XX identifies more than 1 percent of its school population as emotionally disturbed, with some regions identifying fewer than one-fifth of one percent of the population (TEA, June 1989, p. 114). Appendix 2.4 summarizes the number of ED students identified by region.

Table 2.5. Seriously Emotionally Disturbed Students in Texas 1986 -- 1989

	1986-1987	1987-1988	1988-1989
Total Number of SED Students	31,596	33,682	36,840
Total Special Education Population	379,623	393,480	411,783
SED Percentage of Special Education	8.0	8.5	8.9
Total School Population	3,337,593	3,366,194	3,398,808
SED Percentage of Total School Population	.95	1.0	1.1

Source: TEA, Superintendents' Annual Report, 1989, (Computer Printout.)

Table 2.6. State of Texas Special Education Services for Seriously Emotionally Disturbed Students by Age 1986 -- 1989

Age of Students	1986-87 Number	%	1987-88 Number	%	1988-89 Number	%
0 - 2	0		0		0	
3 - 5	422	1.3	419	1.2	435	1.2
6 - 11	10,546	33.0	11,316	34.0	12,038	32.7
12 - 17	19,642	62.0	20,913	62.0	23,054	62.6
18 - 21	986	3.0	1,034	3.0	1,313	3.5
Total	**31,596**		**33,682**		**36,840**	

Source: TEA, Superintendents' Annual Report, 1989, (Computer Printout.)

Table 2.7. State of Texas Special Education Services for Seriously Emotionally Disturbed Students by Ethnicity 1986 -- 1989

	1986-87		1987-88		1988-89	
	Number	%	Number	%	Number	%
Indian/AK	55	.17	41	.12	55	.15
Asian	140	.44	160	.47	153	.42
Black	4,548	14.00	4,947	15.00	5,385	15.00
Hispanic	6,098	19.00	6,652	20.00	7,352	20.00
White	20,755	66.00	21,882	65.00	23,895	65.00
Total	**31,596**		**33,682**		**36,840**	

Source: TEA, Superintendents' Annual Report, 1989, (Computer Printout.)

INTRA-AGENCY AND INTERAGENCY COORDINATION

TEA cooperates both with other public agencies and private providers in procuring educational services for all handicapped youth being served by these agencies. To provide educational services for SED children, TEA cooperates with public agencies such as TDMHMR, TDHS, TYC, TDCJ (formerly TDC,)[9] and TRC.

Efforts at interagency coordination are both attempted in theory and, to some extent, realized in practice. The Texas Administrative Code explicitly states that the commissioner of education will cooperate with TDMHMR and TYC to ensure state compliance with federal law and regulations for all state-administered programs that provide special education services for handicapped students. Furthermore, the educational programs directed and controlled by TDMHMR, TYC, the Texas schools for the blind and deaf, and the Texas Department of Criminal Justice shall be monitored by TEA to determine compliance with federal and state laws as well as state board regulations (34 CFR 300.2[b)]; Tex. Admin. Code, Ch. 89.201 [g]).

Of all the interagency activities, coordination between TEA and TDMHMR is the most apparent. When seeking funding approval for noneducational community-based support services[10] and/or residential placement of a student with emotional disturbance, mental retardation, or autism, school districts are required to submit a joint application with the local mental retardation authority or local mental health authority for approval of these services. State-level review of the application by both TDMHMR and TEA is also required. Senate Bill 1019, passed by the 71st Legislature in 1989, removed $3.2 million from TDMHMR's budget and allocated $2 million for each year of the biennium directly to TEA for "administration of the noneducational community-based support services to handicapped students currently in residential placement or at risk for residential placement" (TEA, Memorandum, August 18, 1989).

As of Spring 1990, no school districts had applied for this money. There are three reasons for the resistance to use this money. First, the districts are concerned that, should they apply for this money and the legislature fail to appropriate the same amount for the next biennium, then the school district would be held liable to continue the noneducational services through use of their own local funds. Second, the individual applicant requirement is a hindrance to the use of this money. Many school districts have a need for several individuals to receive the noneducational community-based services and would rather submit a list of individuals in order to receive a pool of funds, but regulations stipulate that the applications must be submitted on an individual basis. And, last, these funds are being granted for those noneducational services which the school district should not or could not provide on its own. In this case, most of the noneducational services are equivalent to the related services which the schools are mandated to provide under PL 94-142; therefore, justifying that the school district is unable to provide these services is a delicate process. Members of the joint TEA-TDMHMR Task Force on Emotional Disturbance believe that once a few school districts have successfully applied and received money for noneducational community-based support services, then other school districts will be less hesitant to apply for this money. To aid in this effort, the RSCs have been increasing their efforts to educate the school districts on how to appropriately apply for noneducational services money (Hoagwood, Interview, April 26, 1990).

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[9] According to provisions of the TX. Admin. Code, Ch. 89.201, "the Texas School for the Blind, the Texas School for the Deaf, and the schools within the Texas Department of Corrections shall comply with state and federal law and regulations involving the delivery of special education services to handicapped students and shall be monitored by the Texas Education Agency."

[10] Examples of noneducational community-based services include "before- and after-school care and assistance, in- and out-of-home respite care, attendant care, and case management (helping the student and his or her family obtain services from other human service agencies)" (TEA, August 1989, p. 3).

The relationship between TYC and TEA is one of coexistence rather than cooperation. The students residing in the nine TYC halfway houses receive their educational services from the local school district in the locality of the halfway house. Each of the six TYC residential facilities has its own school, complete with a special education department that can evaluate TYC students for handicapping conditions. The six TYC schools are considered as one independent school district. Table 2.8 provides data on the number of ED youth (diagnosed according to the educational system) receiving special education services at each of the six residential facilities.

Because TYC is a state-operated facility, the TYC schools are eligible for both Chapter 1--Neglected and Delinquent funds and, for eligible handicapped students, Chapter 1--Handicapped funds (Griffin, Interview, January 25, 1990).

TEA is required to monitor the special education programs at the schools operated by the Texas Department of Criminal Justice (TDCJ). Although the TDCJ schools (referred to as the Windham Schools) serve an older population, they do have a special education department, so inmates from 18 through 21 years of age would qualify for a free appropriate education. For FY 1990, the Windham Schools did receive some Chapter 1--Neglected and Delinquent, Chapter 1--Handicapped, and PL 94-142 funds for educating the few students they serve who are within the eligible age range. Beginning in 1991, however, the Windham Schools will no longer receive Chapter 1--Handicapped funds because TDCJ is unable to determine whether many of the new inmates meeting the eligibility criteria for age have resided in a state-operated facility for at least a year, which is another criterion that must be meet in order for a school to qualify for Chapter 1--Handicapped funds. As of December 1, 1989, of the 56 special education students served by the Windham Schools, none were ED students (Yawn, Interview, March 30, 1990).

Services coordinated between the TRC and TEA are the same whether a student is in regular education or in special education. Usually students are referred to TRC by the school's vocational adjustment coordinator (VAC) for job readiness training, work adjustment training, or job placement. Students themselves can elect to participate in TRC programs. After referral to TRC, the youth must meet TRC eligibility criteria before being accepted into a TRC program. All TRC youth clients must be at least 16 years of age and have a handicapping condition.

One deterrent to the schools in utilizing the TRC services is that a recent memorandum of understanding between TEA and TRC requires that TEA pay for the training provided by TRC. In the past, TRC paid for both intake assessment services and training. The relationship between a school district's VAC and TRC's vocational rehabilitation counselors (VRC) also contributes to how often students are referred to TRC, with rural schools utilizing TRC more than urban schools. According to vocational rehabilitation counselor Dan Washam, only 20 of the 120 youth in his active case load are special education students and none are diagnosed as emotionally disturbed (Washam, Interview, January 23, 1989).

School districts may contract with either a TDHS- or TDMHMR-approved facility for residential placement services if a child's IEP so requires. Examples of related services that are provided through interagency coordination include assessments, physical therapy (if it is imperative to the education of the child), and transition for youth between the ages of 16 and 21 from public education to adult services. Special education services provided through the coordination of a school district with another agency must comply with the

Table 2.8. Emotionally Disturbed Students Served by the TYC School System as Reported in the December 1989 Child Count

Facility	ED Students	LD Students	Total Eligible For Chapter 1
Brownwood	41	32	277
Corsicana	89	0	102
Crockett	18	19	129
Gainsville	51	43	365
Giddings	52	29	345
West Texas Children's Home	30	63	219
Totals	**281**	**186**	**1,437**

Source: TYC, Office of the Superintendent of Schools.

standards set forth in PL 94-142. Funding for these contracted services is provided according to the formula for special education funding which utilizes instructional arrangement weights and contract hours.

If an IEP requires that a child be placed in any instructional arrangement that requires an off-campus setting, then the local school district must contract with either a public or private agency that can provide the required service in the least restrictive environment and at the lowest cost. Despite these requirements of least restrictive environment at the lowest cost, the most restrictive and costly instructional arrangement, that of Hospital Class, has been utilized the most over the last three years in comparison to the other instructional arrangements (Table 2.9). The Hospital Class arrangement has become markedly more common because of the increased availability of hospital space as opposed to less restrictive facilities (Crow, Interview, November 10, 1989). An increase in the number of private psychiatric and substance abuse hospitals being built and utilized has also contributed to the large number of children placed in hospitals (Craig, Interview, December 8, 1990). Another explanation for the high number of SED children in hospitals is that many children who are in the hospitals may be categorized as SED or ED inappropriately (Craig, Letter, March 19, 1990). Additionally, most of the ED students placed in the Hospital Class arrangement do not remain in that arrangement all year long. Students hospitalized for substance abuse may represent that category of inappropriately identified ED students in Hospital Class arrangements that move rapidly in and out of the arrangement.

POSSIBILITY OF MEDICAID FUNDING

TEA, through its Division of Interagency Coordination, is currently developing a plan that would allow school districts to utilize Medicaid funds to help pay for related services such as psychological and medical evaluations and therapy for each handicapped student meeting Medicaid criteria. Obstacles such as the need to amend the State Medicaid Plan and the need to develop provider definitions, service definitions, as well as coding methods have hindered the process. The federal bureaucracy is also constructing barriers to prevent already large Medicaid user pools from increasing (Crow, Interview, November 10, 1989). For more details on how the school districts could access Medicaid funds, refer to Chapter 14 of this volume, which discusses Medicaid in detail.

COORDINATED SERVICES IN OTHER STATES

The term "continuum of care" has been used to describe the range of services needed by severely disturbed children and youth. This system of care denotes a range of program components with varying levels of intensity. The TEA-TDMHMR Joint Task Force summarized the nature of the situation with these words:

> At the present time, the ideal continuum of care does not exist for the children of Texas. Lack of agency funding and lack of interagency cooperation to improve existing services contribute to this problem. The past legislative session addressed the latter aspect of the problem by producing several mandates to encourage interagency cooperation in developing services which address the needs of multiproblem children such as the SED child. (TEA, June 1989, p. 132)

A number of states around the country have been successful in coordinating services to better meet the needs of the seriously emotionally disturbed population. Services often include joint projects such as day treatment programs that pool resources of both the educational and mental health systems. There are successful programs in Maryland, Florida, and Virginia, for example.

Table 2.9. State of Texas Special Education Services for Seriously Emotionally Disturbed Students by Instructional Arrangement 1986 -- 1989

	1986-87		1987-88		1988-89	
	Number	%	Number	%	Number	%
Regular Campus						
Regular Class	974	3.0	1,019	3.0	1,171	3.0
Spec Ed Resource	12,427	39.0	12,488	37.0	12,898	35.0
Partially Self-Contained	4,438	14.0	4,209	12.0	3,984	11.0
Self-Contained	5,840	18.0	6,838	20.0	7,801	21.0
Separate Campus	1,380	4.0	1,457	4.0	1,520	4.0
Homebound	302	.9	315	1.0	303	.2
Home-based	69	.2	76	.2	75	.2
Hospital Class	5,300	17.0	6,440	19.0	8,265	22.0
Hospital Bedside	56	.2	74	.2	35	.1
Community Center	327	1.0	327	.9	368	1.0
Multidistrict Class	327	1.0	271	.8	271	.7
Nonpublic School						
Day	61	.2	47	.1	50	.1
Residence	95	.3	123	.4	99	.3
Total	**31,596**		**33,682**		**36,840**	

Source: TEA, Superintendents' Annual Report, 1989, (Computer Printout.)

Maryland has developed three (3) day treatment programs that are operated by both the Department of Education and the Department of Mental Health and Mental Retardation. The Department of Education supplies the buildings and the teachers, while the Department of Mental Health and Mental Retardation supplies all the therapy. The State of Maryland has realized that, even though PL 94-142 mandates that counseling and mental health services should be paid for by the schools, these services cannot be provided without joint efforts. The system has been very successful (Appendix 2.5 contains a description of the Maryland system).

The State of Florida has developed a multiagency service network for severely emotionally disturbed students. The creation of this program has required that both the mental health and education systems acknowledge their assets and deficits and be willing to modify their approach to improve services to the target population.

Virginia is now in the process of setting up a multiagency project to address the needs of SED children. Through interagency coordination, the Virginia Department of Social Services, Department of Corrections, Department of Mental Health, Mental Retardation, and Substance Abuse Services, and the Department of Education have created an Interagency Pool to help localities meet the needs of SED children.

CURRENT ISSUES OF CONCERN

An issue that has received a good deal of attention lately is that of "least restrictive environment." Congress included this requirement as one of the provisions of PL 94-142 to encourage the movement toward integrating handicapped students with nonhandicapped students in the public schools. Local school districts have had to expand their special education departments substantially to accommodate the requirements of the LRE provision.

When the federal government monitored the Texas special education program, a preliminary investigation determined that Texas was not complying with the LRE provision. In response to this assessment, TEA has published two documents that will be distributed to the localities to help them interpret and comply with the LRE requirement. The two publications are entitled "All Children Can Learn Together: Suggestions for Least Restrictive Environment" and "All Children Can Learn Together: Guidelines for Least Restrictive Environment."

Kimberly Hoagwood, education specialist for TEA, expects that part of the problem of noncompliance is due to ignorance on how to provide the necessary services. There are numerous small, rural school districts in Texas that do not have any "experts" in the field of child psychology. The tendency in Texas has been to provide the very basic special education resources and, if that does not work, to then send the child to a residential program. The reason for this trend can be explained primarily by two factors: financial constraints on providing all the intermediary services and lack of expertise on what needs to be provided (Hoagwood, Interview, November 10, 1989).

In order to alleviate this problem, TEA has been developing a "trainer of trainers" program. Each of the 20 regional ESCs in Texas has a staff person who can be called on by the individual districts for assistance in anything relating to the education of ED children. TEA is committed to training these designated individuals in order to acquire consistency across the state. TEA is also in the process of developing a factor analysis of behaviors that can be used by the localities to help them determine whether a child ought to be assessed. Cecil Reynolds from Texas A & M University, a nationally recognized expert in the field of test construction, was commissioned to design the analysis. The analysis has yielded very good predictive results, and a user's manual for the screening instrument will be available in August 1990 (Hoagwood, Interview, November 10, 1989).

A second issue that needs to be considered when developing policies for SED children is the issue of labeling or categorizing a child as SED. This issue of is a difficult one because it can have both positive and negative effects. The label can open doors to opportunity in the form of evaluation and research, legislation, funds, and special services and programs, but it can also diminish competence and self-esteem, create alienation, or permanently stigmatize a child.

The problems of the self-fulfilling prophecy and teacher expectations must also be considered. Teachers, classmates, family members, classroom atmosphere, curriculum, and teaching methods all convey to a child what he or she is expected to accomplish. These messages that the labeled child is receiving determine to a great extent feelings about what he or she is capable of and how he or she should behave. Labeling further hinders a student's education because "special class teachers expect less of their students than do regular class teachers and make fewer demands upon students whom they perceive as having low ability" (Hobbs, 1975, p. 35).

Many SED children are placed in special classroom settings, yet there is little evidence that the benefits of such placement outweigh the negative consequences of being put in these classes. In the case of the retarded child, academic achievement in special classes has been shown to be either equal or inferior to that of children with comparable IQs who remained in the regular classes (Hobbs, 1975).

PL 94-142 does address some of the concerns of labeling. First, the law allocates funds to the most normal and least stigmatizing agency. Second, the law requires that a child be placed in the least restrictive environment which will help diminish the negative impact of labeling. Third, the funding formula allocates funds according to services provided rather than by categorization of the child, thereby not forcing the school to put a label on each child.

Since no child fits into a predetermined category, it is often difficult to know what environment is best for a particular child. There is no concrete set of guidelines to follow that stipulates, for example, that if a child begins to do required work and acts less aggressive, he or she should then be put back into the regular classroom. Therefore, it is difficult to monitor whether schools are complying with the least restrictive environment provision. Perhaps there should be some incentive to reward schools that have more SED children in regular classrooms. There are no easy answers to the problems that labeling creates for children and their families. However, policymakers should be aware of the potential damage and work to minimize it.

A third obstruction to developing sound policy for the seriously emotionally disturbed is the lack of research about key aspects of the current programs that serve SED students. This research could help policymakers, program strategists, school officials, mental health officials, and parents to develop better identification methods, provide better services, and foster interagency projects.

First, more research is needed on the SED population itself. National figures collected and reported annually to Congress by the Department of Education (DOE) fail to describe in enough detail the characteristics of the children or the services they receive. Schools are identifying a little better than 10 percent of the most seriously disturbed youth, but discrepancies exist between the identification rates from state to state. For example, Colorado identifies 17.5 percent of its special education population as SED while Arkansas identifies only 1 percent as SED. These discrepancies are probably due more to differences in state and local policies and assessment procedures than from differences in the children from each state. This suggests that more research is needed to discover why the discrepancies exist and how these differences can be eliminated to better identify and serve the seriously emotionally disturbed population (Knitzer, 1989, p. 4).

Second, more research is needed concerning how race and socioeconomic status impact upon the identification of SED students. Data from the DOE suggest that "minority children are both under and over-represented. According to 1986 data, Native American, Asian, and Hispanic children may be somewhat under-represented, while Black children are over-represented. (Overall, 35 percent of the SED population is minority, compared to 30 percent of the total school population.)" (Knitzer, 1989, p. 6). Even less is known about the socioeconomic status of SED children. A six-state sample study by the Florida Center for Research and Training in Children's Mental Health suggests that more SED children come from low-income families than from middle- and high-income families.

Third, there is a void of knowledge concerning the educational and support services that the SED population is receiving. The educational services provided to the SED population have been cited as unmotivating, too rigidly structured for children in regular education, much less special education, and devoid of social skill-building activities. Teachers of SED students have the highest burnout rate among teachers of handicapped children. Transitional services which assist SED children in moving from a restrictive environment to a less restrictive environment fail to exist in most special education programs.

Data regarding what type of noneducation services the SED students receive are also lacking. According to the DOE's Tenth Annual Report to Congress, "17 percent of the SED population receives psychological services (although what this means, and how it differs from child counseling is not defined, and further, the tables and the text are inconsistent)" (Knitzer, 1989, p. 7). There is no clear information on how many children get mental health services that are not specifically designated in the IEP.

More information is needed about how the various programs move a child through the special education program. Do most move from resource room to self-contained classroom without access to more enriching services? How do programs attempt to incorporate the families of the children into the services provided to the child? Are these programs successful? Why are national dropout rates for SED students one and one-half times as great as for the entire special education population?

Various studies on innovative programs that attempt to serve both the identified SED population and those at risk of emotional disturbance do exist, as do success stories about school and mental health collaborations for providing support services to SED children and their families. But all too often the research stops short of answering the sticky question of whether ideal written policy is consistent with what occurs in implementation. Moreover, coordination should be accomplished so that mental health services can be added to each school-based SED program.

Last, research needs to be a collaborative effort between the appropriate public agencies and the research community. Jane Knitzer, author of Unclaimed Children, strongly advocates targeted money to encourage researchers to tackle these often tough and methodologically messy questions, "perhaps through a new discretionary grant program under PL 94-142, perhaps along with a broader service mandate through a modified version of CASSP (Child and Adolescent Service System Program)" (Knitzer, 1989, p. 17). The system for providing the available information to policymakers, agency personnel, and parents needs to be improved. The scope of these suggestions is vast, but the improvements in the system of care for SED youth since the enactment of PL 94-142 should be an encouragement.

CONCLUSIONS

As the TEA-TDMHMR Joint Task Force data illustrate, Texas schools need to identify a greater number of SED youth. The screening instrument developed and tested by the task force for use by teachers and parents could make initial referral for assessment of emotional disturbance easier. One way to increase identification of SED youth is to require that the school districts make early referral screening available to parents, teachers, and counselors and to conduct workshops on how to use the screening instrument. Currently, school districts can choose whether to use the screening instrument. Additionally, TEA needs to develop a better system for providing assessment personnel in the rural, sparsely populated regions of Texas. Perhaps a system of itinerant psychologist or psychological assessment personnel could be made available to the rural districts that lack access to these services in their surrounding communities.

Once the students are diagnosed as SED, there is a need for a greater array of services to be made available. In regard to the instructional arrangement, there is a need for day treatment facilities and crisis centers across the state. This lack of intermediate care facilities encourages more restrictive, inappropriate placements such as residential or psychiatric hospital placements because of the greater availability of these facilities.

The $2 million appropriated to TEA for use in providing noneducational community-based care on an individual basis can help address the need for placement in the least restrictive environment, but it fails to address the fact that these services are often not available in a community. Furthermore, the restriction that the individual must be either currently in residential placement or at risk of residential placement tends to negate the use of the $2 million for much needed counseling services for that SED population which can be served in a self-contained or partially self-contained classroom.

The fact that few SED students receive, at best, an hour of therapeutic counseling a week suggests that there is an overwhelming need for mental health services to be provided in conjunction with the educational curriculum. In addition, school personnel express the need for after-school programs for all students who lack adequate supervision between the time the school day ends and a parent comes home from work.

A logical solution to providing greater mental health services and after-school care is to make the schools the one place for such services to be delivered. The School of Tomorrow is a pilot project that is currently underway in four Texas schools which focuses on using the schools as the avenue through which an array of social welfare, mental health, and educational services are provided to at-risk children and their families. The project is sponsored by the Hogg Foundation and will last for five years, after which time it will be renewed if it is successful. A comprehensive evaluation is being performed in order to determine the project's success.

Ordaining the schools as the clearinghouse for an array of public services will require a central office or department to coordinate the different agency activities. Parents and school personnel agree that the coordination of such efforts should be managed by an entity independent from any of the cooperating public agencies. A very important issue that surfaces when considering a coordinated system concerns where the resources should come from. A word of caution would be to not use money in existing public agency programs to fund these efforts. Stretching already attenuated resources fails to accomplish any greater goal.

An already existing service that is provided by the schools and which needs to be expanded is that of case management. When studying the Austin Independent School District (AISD), it became apparent that the role of the visiting teacher is a crucial link between the schools and the families of at-risk students. The term "at-risk" covers a wide variety of situations. A few of these include at risk of dropping out of school, becoming pregnant, or becoming a substance abuser. The visiting teachers perform services such as (1) gathering sociological data on students who are to be assessed for emotional disturbance, mental retardation, or a multihandicapping condition, (2) helping the parents understand their role on the ARD Committee, and (3) helping the family find needed mental health or social services. The AISD budget for the visiting teachers has been cut over the last seven years; there are currently 13 visiting teachers, who served 3,000 students in 1989. Clearly this type of case management service needs to be adequately funded and staffed in all school districts.

The transitional services for students moving from a more restrictive special education placement to a less restrictive environment, or vice versa, are lacking. Students moving from the highly structured atmosphere of a self-contained classroom need to be provided the skills to be able to cope in a partially self-contained classroom. TEA needs to focus on developing programs that will help the emotionally disturbed student learn the social and coping skills that will allow him or her to function in a less controlled environment.

A final recommendation would be for increased funding for research on how to identify emotional disturbance at an earlier age and, once identified, how to best serve the educational and mental health needs of the special education student and the student's family. If the schools and other social welfare agencies fail to address the familial situations of the emotionally disturbed student, the education and rehabilitation of this population will be impossible.

Appendix 2.1. PL 94-142 Federal Funding Formula

The following is a layperson's explanation of the PL 94-142 federal funding formula. It represents the formula stipulations put forth in 34 CFR 300.611.

The Congress first appropriates a sum based on assumed or projected numbers of PL 94-142 children. Second, a small percentage is allocated to the Bureau of Indian Affairs (BIA) to fund special education in the territories such as Guam, the Virgin Islands, and American Samoa, among others. The secretary has the discretion of appropriating up to 1 percent for the territories.

The balance is what is left for the states. In theory, the states are allowed full funding up to 40 percent of excess cost. This figure is equal to 40 percent of the average per-pupil expenditure in public elementary and secondary schools in the United States. However, since Congress never appropriates the full amount, the amount per pupil is ratably reduced by the proportion that the appropriation falls short of the statutory maximum. Each state receives its share based on its pupil count.

What follows is the most current regulation pertaining to state allocation:

Subpart G--Allocation of Funds Reports

Allocations

Sec. 300.700 Special definition of the term State.

For the purposes of Sec. 300.701, 300.702, and 300.704-300.708, the term "State" does not include Guam, American Samoa, the Virgin Islands, and the Trust Territory of the Pacific Islands.

Sec. 300.701 State entitlement formula.

(a) The maximum amount of the grant of which a State is entitled under section 611 of the Act in any fiscal year is equal to the number of handicapped children aged three through 21 in the State who are receiving special education and related service, multiplied by the applicable percentage, under paragraph (b) of this section, of the average per pupil expenditure in public elementary and secondary schools in the United States.

(b) For the purposes of the formula in paragraph (a) of this section, the applicable percentage of the average per pupil expenditure in public elementary and secondary schools in the United States for each fiscal year is:

(1) 1978--5 percent,
(2) 1979--10 percent,
(3) 1980--20 percent,
(4) 1981--30 percent, and
(5) 1982, and for each fiscal year after 1982, 40 percent.

(c) For purposes of this section, the average per pupil expenditure in public elementary and secondary schools in the United States means the aggregate expenditures during the second fiscal year preceding the fiscal year for which the computation is made (or if satisfactory data for that year are not available at the time of computation, then during the most recent preceding fiscal year for which satisfactory data are available of all local educational agencies in the United States (which, for the purpose of this section, means the fifty States and the District of Colombia), plus any direct expenditures by the State for operation of those agencies (without regard to the source of funds form which either of those expenditures are made), divided by the aggregate number of children in average daily attendance to whom those agencies provided free public education during that preceding year.

Sec. 300.703 Ratable reductions.

(a) General. If the sums appropriated for any fiscal year for making payments to States under Section 611 of the Act are not sufficient to pay in full the total amounts to which all States are entitled to receive for that fiscal year, the maximum amount which all States are entitled to receive for that fiscal year shall be ratably reduced. In case additional funds become available for making payments for any fiscal year during which the preceding sentence is applicable, those reduced amounts shall be increased on the same basis they were reduced.

Appendix 2.2. State Education Funding Formula

Instructional Arrangements (See Footnotes)	Use These Numbers in Column 2 Only	Use These Numbers in Column 6 Only	1	x	2	x	3	/	4	=	5	x	6	=	7	x	8	=	9
			Number of Students		Number of Hours Assigned by TEA		Number of Days Per Week Attended		Number of Hours in Standard Instruct. Week		Percent of One		Weight of the Instructional Arrangement		Percent of One Weighted FTE		Your District's ABA in		Est. Amt. of State Sp. Ed. Funds Generated
	HOURS	WT																	
Resource Room	2	2.7	1	x	2.0	x	5	/	30	=	.33	x	2.7	=	.899	x	$1677	=	$1507
Self Contained Mild-Moderate	3.25	2.3	1	x	3.25	x	5	/	30	=	.541	x	2.3	=	1.245	x	$1677	=	$2089
Self Contained Severe-Reg. Campus	5.5	3.5	1	x	5.5	x	5	/	30	=	.916	x	3.5	=	3.208	x	$1677	=	$5380
Self contained-Separate Campus	5.5	2.7	1	x	5.5	x	5	/	30	=	.916	x	2.7	=	2.474	x	$1677	=	$4150
Multi District	4.25	3.5	1	x	4.25	x	5	/	30	=	.708	x	3.5	=	2.479	x	$1677	=	$4157
VAC	5.5	2.3	1	x	5.5	x	5	/	30	=	.916	x	2.3	=	2.108	x	$1677	x	$3535
Community Class	4.25	3.5	1	x	4.25	x	5	/	30	=	.708	x	3.5	=	2.479	x	$1677	x	$4157
Self Contained Pregnant	4	2.0	1	x	4.0	x	5	/	30	=	.666	x	2.0	=	1.333	x	$1677	x	$2235
Homebound	1	5.0	1	x	1.0	x	5	/	30	=	.166	x	5.0	=	.833	x	$1677	=	$1397
Hospital Class	4.5	5.0	1	x	4.5	x	5	/	30	=	.75	x	5.0	=	3.75	x	$1677	=	$6288
Speech Therapy 1	.25	7.11	1	x	.25	x	5	/	30	=	.0416	x	10.0	=	.296	x	$1677	=	$496
State School Students 2	5.5	5.0	1	x	5.5	x	5	/	30	=	.916	x	5.0	=	4.58	x	$1677	=	$7686
Residential Care and Treatment (Out of District) 2,3	5.5	5.0	1	x	5.5	x	5	/	30	=	.916	x	5.0	=	4.58	x	$1677	=	$7686

FOOTNOTES

1 **Speech Therapy** - This is a new weight for speech therapy. Do not use the old weight of 10.0 to calculate your estimate. Use the weight of 7.11.
2 **State School ~ Residential C/T** - These are new instructional arrangements.
3 **Residential C/T** - This I.A. is for residentially placed students, served by the district, but whose parents are not residents of the serving district.
4 **ABA** - The figure shown, $1677, is the state average ABA. Make sure to use your own district's ABA in your calculation.

Source: TEA, Division of Special Education Funding and Compliance, 1989. (Mimeograph.)

Appendix 2.3. Instructional Arrangements and Settings

The following is a description of the instructional arrangements into which special education students are assigned by the ARD Committee.

1. Resource Room. This instructional arrangement is for providing special education instruction and related services in a school district setting for less than 50 percent of the regular school day. This arrangement also includes services provided by a special education itinerant teacher (one who provides instruction to handicapping students on more than one campus). Regardless of the percentage of time the student spends in special education, this arrangement includes any supportive special education services provided in a regular class such as that provided by helping teachers, interpreters, and special education aides working directly with handicapped students.

2. Self-contained, Mild and Moderate, Regular Campus. This instructional arrangement is for providing special education instruction and related services to mildly to moderately handicapped students who are in a self-contained program for 50 percent or more of the regular school day on a regular school campus.

3. Self-contained, Severe, Regular Campus. This instructional arrangement is for providing special education instruction and related services to severely handicapped students who are in a self-contained program for most of the regular school day on a regular school campus. Students may be capable of attending no more than two regular education classes (such as music, physical education, or art).

4. Self-contained, Separate Campus. This instructional arrangement is for providing special education instruction and related services to students who are in a self-contained program at a separate campus operated by the school district that provides only special education instruction. This arrangement includes services provided to special education students at an off-campus facility leased or arranged for by the school district for the purpose of providing special education to district students.

5. Multidistrict Class. This instructional arrangement is for providing special education instruction and related services to students from more than one school district served in a single location. These special education services are not otherwise available in the respective sending districts.

6. Vocational Adjustment Class. This instructional arrangement is for providing special education instruction to students who are placed on a job with regularly scheduled supervision by special education teachers. A student in part-time job training/employment receives a minimum of two hours daily of job-related instruction. Handicapped students may participate in other occupational preparation programs (which do not generate special education funds) including regular vocational education, coordinated vocational academic education (CVAE) classes, and vocational education for the handicapped (VEH) classes.

7. Community Class. This instructional arrangement is for providing special education instruction and related services to students whose instruction is provided by the school district's special education personnel in a facility not operated by a school district which also provides other services for handicapped individuals. This instructional arrangement includes sheltered workshops for handicapped students. A student participating in a sheltered workshop must receive at least one hour per day of special education instruction.

8. Self-contained, pregnant. This instructional arrangement is for providing special education instruction to eligible pregnant students whose instruction is provided in a self-contained situation. A class serving only pregnant students may not be considered as any other instructional arrangement.

9. Homebound. This instructional arrangement is for providing special education instruction to eligible handicapped students who are served at home or hospital-bedside. Students served on a homebound or hospital-bedside basis are expected to be confined for a minimum of four consecutive weeks as documented by a physician licensed to practice in the United States.

10. Hospital Class. This instructional arrangement is for providing special education instruction in a classroom in a hospital facility or an approved residential care and treatment facility not operated by the school district. Students served in this instructional arrangement are expected to reside in the facility a minimum of four consecutive weeks as documented by an appropriate authority. Students served in but not residing in the facility are considered to be in a community class instructional arrangement. If the students residing in the facility are provided special education services outside the facility, they are considered to be served in the instructional arrangement in which they are placed and are not to be considered as in a hospital class.

11. Speech Therapy. This instructional arrangement is for providing speech therapy services.

12. Nonpublic Day School. This instructional arrangement is for providing special education instruction to students through a contractual agreement with an approved nonpublic school for special education (Tex. Adm. Code, Ch. 89.242 [c]).

13. Residential Placements. This instructional arrangement is for providing special education instruction to eligible handicapped students who reside in approved care and treatment facilities and whose parents do not reside within the boundaries of the school district providing educational services to the student. In order to be considered in this arrangement, the services must be provided on the school district campus. If the instruction is provided at the facility rather than on the school district campus, the instructional arrangement is considered to be the Hospital Class. Placement of a student at the facility for care/treatment does not automatically make the student eligible for special education. Students must meet special education eligibility requirements to be considered in this instructional arrangement. Students served in this instructional arrangement are expected to reside in the facility a minimum of four consecutive weeks as documented by an appropriate authority (TEA, 1990, p. 9).

14. Mainstream. Mainstream is the instructional arrangement in which a special education student is receiving special education instruction in the regular education classes.

Appendix 2.4. Percentage of School Population Identified as Emotionally Disturbed by Region and County

Number of Texas School Districts Identifying Certain Percentages of Their Children as Emotionally Disturbed

ID's as ED	Districts with This Rate	Percentage of Total
10% or Above*	4	.0038
9% - 9.99*	2	.0019
8% - 8.99*	0	.0000
7% - 7.99*	1	.0009
6% - 6.99*	2	.0019
5%	0	.0000
4% - 4.99	1	.0009
3% - 3.99	4	.0038
2% - 2.99	23	.0217
1% - 1.99	89	.0838
.050 - .99%	202	.1902
.001 - .049%	383	.3606
0.00	351	.3305
Total	1,062	1.00

* Large percentages are mostly from districts impacted by a mental health placement facility within their borders.

Appendix 2.4 (Continued). Percentage of School Population Identified as Emotionally Disturbed by Region and County

ED Identification Performace by Region

Rank	Region	Population ID'd as ED (Regional Basis)	Number of Districts Meeting 1% of Pop. Criteria	Districts Meeting 1% of Pop. Criteria
1	Region 20	1.65%	22 of 47	47%*
2	Region 13	0.98%	12 of 56	21%*
3	Region 7	0.79%	25 of 99	25%*
4	Region 2	0.75%	5 of 44	11%
5	Region 12	0.74%	10 of 79	13%
6	Region 6	0.68%	7 of 57	12%
7	Region 4	0.67%	11 of 55	20%*
8	Region 11	0.64%	6 of 77	8%
	Region 14	0.64%	5 of 47	11%
9	Region 19	0.53%	1 of 13	8%
10	Regopm 10	0.52%	3 of 81	4%
11	Region 3	0.46%	3 of 41	7%
12	Region 9	0.45%	1 of 40	3%
13	Region 16	0.38%	1 of 71	1%
14	Region 1	0.30%	3 of 37	8%
15	Region 15	0.27%	2 of 45	4%
16	Region 5	0.22%	0 of 29	0%
	Region 18	0.22%	0 of 33	0%
17	Region 8	0.15%	0 of 48	0%
18	Region 17	0.13%	0 of 63	0%
	State Total		117 of 1,062	11%

* Regions 20, 13, 7, and 4 are the most consistent regions in their identification of emotionally disturbed students.

(Continued Next Page)

Appendix 2.4 (Continued). Percentage of School Population Identified as Emotionally Disturbed by Region and County

Identification of Emotionally Disturbed Students in All Districts in Texas With More Than 30,000 Students

District	County	Total Population	No. of EDs	% of Pol. ED
Northside ISD	Bexar	44,776	1,144	2.55%
Northeast ISD	Bexar	38,062	942	2.47%
Austin ISD	Travis	60,904	852	1.40%
San Antonio ISD	Bexas	61,084	760	1.24%
Fort Worth ISD	Tarrant	68,045	667	0.98%
Richardson ISD	Dallas	39,921	311	0.94%
Pasadena ISD	Harris	35,097	316	0.90%
El Paso ISD	El Paso	61,616	470	0.76%
Garland ISD	Dallas	34,288	245	0.71%
Aldine ISD	Harris	38,107	256	0.56%
Cypress-Fairbanks	Harris	33,104	186	0.56%
Brownsville ISD	Cameron	33,966	162	0.48%
Houston ISD	Harris	194,389	873	0.45%
Dallas ISD	Dallas	132,389	529	0.40%
Arlington ISD	Tarrant	40,620	129	0.32%
Ysleta ISD	El Paso	48,653	95	0.20%
Lubbock	Lubbock	30,313	57	0.19%
Totals		**995,334**	**7,994**	**0.80%**

Identification of Emotionally Disturbed Students in All Districts in Texas with Fewer than 200 Students

Total Number of Texas School Distrist with Fewer than 200 Total Students	182
Total Number of Students in the 182 Districts	21,181
Total Number of ED Students Identified in the 182 Districts	74
Percentage of Total ED Total Population	0.35
Average Number of Students in Above Districts	116
Average Number of ED students in Above Districts	0.41

Source: TEA, June 1989, pp. 127-128.

Appendix 2.5. Maryland System

The Regional Institute for Children and Adolescents (RICA) in Rockville is a residential and day treatment facility that is operated jointly by the State of Maryland's Department of Health and Mental Hygiene and the public school system of Montgomery County. The program has the capacity for 100 day students and 80 residential students. It also offers a special eight- bed, 45- to 60-day evaluation unit for adolescents who have been placed by the juvenile courts of Montgomery and Frederick counties for psychological, educational, social, and psychiatric testing as well as for recommendations for placement.

RICA is located in a facility built in 1980 on 14.6 acres of land that was donated to the state by Montgomery County. Located on the same site is a general hospital, a private psychiatric hospital, an ambulatory care facility, a long-term care facility, and a state-funded 30-bed juvenile detention center. The RICA building is an attractive, one-story brick structure containing a large educational and clinical unity with therapy rooms, professional conference rooms, administrative offices, classrooms, vocational and crafts workshops, a gymnasium, an infirmary, and dietary services. This central core is interconnected to three cottages, which house the adolescents in the program. Each cottage has three or four units with eight youth in each unit. An outdoor recreational area is adjacent to these buildings.

HISTORY OF THE PROGRAM

RICA-Rockville is patterned after a similar Regional Institute for Children and Adolescents in Baltimore, Maryland. The planning of the Rockville facility took almost ten years before it actually opened. RICA-Rockville grew out of a community concern, especially on the part of the judges, that severely emotionally disturbed children and youth were either being served inadequately in the county or in inappropriate settings. The planning process that ensued was long and highly political, entailing extensive negotiations between various levels of government and community groups. At one point, Montgomery County was going to operate the entire program but was ultimately deterred by cost concerns. Finally, the State Department of Health and Mental Hygiene agreed to run the program in partnership with the county school system.

CLIENT POPULATION

RICA's residential treatment program accepts youth ranging in ages from 12 to 20 years from three Maryland counties. The day treatment program serves a younger population, 6 to 20, all of which reside in Montgomery County. In both the residential and day treatment program the majority of the youth are 12 to 15 years old. There are approximately four times as many boys in the program as girls.

The program treats youth with a wide range of problems. Virtually all have had previous psychiatric treatment: 88 percent have been in outpatient therapy; 55 percent in special education programs; 38 percent in psychiatric hospitals; and 24 percent in an out-of-state residential treatment facility. Approximately 40 percent of RICA students are court-involved.

THE PROGRAM

All referrals to RICA, even those from the court, came through the school system up until 1985. Now referrals come from other sources directly to RICA rather than through the school system. Clinical and school staff review all referrals and determine the appropriateness of the child for placement. A formal assessment and diagnostic workup is conducted prior to admission either by RICA's evaluation unit or another facility. When a child is admitted into the program, whether for residential or day treatment, the child is assigned to a team. The child is then assigned to a therapist and oriented to the program with his/her parents.

Programs at RICA are comprehensive and multidimensional and include day treatment; residential treatment; individual, group, and family therapy; creative services therapy; and a fully accredited special education school with both academic and vocational programming.

EDUCATION COMPONENT

The RICA-Rockville school program operates from 9:30 a.m. to 3:30 p.m. from September through June. It is designed to serve both residential and day students whose needs cannot be met in a regular school or less restrictive, special education setting. The primary emphasis of the school program is a combined focus on academic achievement and social/emotional skills development.

The teaching staff for the school program are hired and paid by the Montgomery County school system. Academic instruction follows the Montgomery County curriculum but is individually tailored to meet the needs and the grade level of each student in the program. There are five educational programs: one for elementary students, one for middle school students, two senior high teams, and a vocational team. Each team (except vocational) consists of one program assistant, one alternative structure teacher, three to four teacher advisors, and four to five special education instructional assistants. The program also includes an evaluation unit for eight court-placed students. Additional support staff include science teachers, physical education instructors, and media specialists. Elementary students are grouped by grade and remain with one teacher, although specialists come into the classroom.

A unique aspect of RICA's school program is the process it has developed for mainstreaming its day students into a regular school program. A special staff person, called a "mainstreaming specialist," has been hired by the school system to facilitate the transition. When a youth is ready to mainstream, the mainstream specialist makes contact and appropriate arrangements with personnel in the home school. Students mainstream into regular classes at a regular school for one or two periods at a time until they have achieved success and can progressively move to a heavier schedule. The role of the mainstream specialist is to support the child and to serve as a liaison between the RICA program staff and the regular school setting. Thus, the mainstream specialist monitors a child's progress in the regular classroom, meets with home school teachers every two weeks, and provides written feedback and evaluation to all RICA staff involved with the child.

FUNDING AND BUDGET

RICA's funding base, which results from a partnership of a state department of health and mental health and a large, progressive county school system, is unique and substantial. The 1985 budget appropriation for RICA from the State of Maryland was $5,419,501. This included $3.5 million in salaries and wages and $1.9 million in operating expenses. The Montgomery County school system contributed over $1 million to the program in salaries, wages, and direct supplies. Other counties reimbursed Montgomery for students that they referred to the program. In 1985, the annual per capita cost for a residential student was calculated to be $41,054 and for a day student, $25,092.

Each year RICA develops a budget which is submitted to the State Department of Health and Mental Hygiene. It is then subject to the review and approval of the budget committees of the state legislature, where funding is ultimately appropriated.

RESEARCH AND EVIDENCE OF EFFICACY

RICA staff believe that its evaluation program is limited and needs to be improved; steps are underway to accomplish this. RICA currently uses the Achenbach Child Behavior Checklist (youth in the program have improved on this test); the Pupil Observation System (results show progress was made by students); and the Family Assessment Device. A collaborative study with the University of Maryland is also underway to conduct face-to-face interviews with students up to three years after discharge.

PROGRAM NEEDS AND FUTURE PLANS

RICA does not plan to grow in size because it has a limited licensed bed capacity. According to the CEO, however, there are a number of areas he would like to develop. One area involves the creation of a separate foundation that could raise money to support additional research and education programs. Another area of concern and involvement is the expansion of state services to develop a continuum of care. Group homes are considered to be a missing link in a system that now offers acute and residential care and two Regional Institutes for Children and Adolescents, which focus on mainstreaming to a less restrictive environment.

References

Craig, Richard. 1989. Educational Program Director, Division of Special Education Funding and Compliance, Texas Education Agency, Austin, Texas. Interview by Mary Ann Kaminski, September 26 and December 8.

____________. 1990. Educational Program Director, Division of Special Education Funding and Compliance, Texas Education Agency, Austin, Texas. Letter to Mary Ann Kaminski, March 19.

Crow, Kenneth. 1989. Director, Division of Interagency Coordination, Texas Education Agency, Austin, Texas. Interview by Mary Ann Kaminski, November 10.

Griffin, Byron. 1990. Superintendent of Schools, Texas Youth Commission, Austin, Texas. Telephone interview by Mary Ann Kaminski, January 25.

Haak, Ruth. 1989. Special Education Director, Balcones Special Service Cooperative, Austin, Texas. Interview by Mary Ann Kaminski, December 6.

Hoagwood, Kimberly. 1989. Education Specialist, Division of Program Evaluation, Texas Education Agency, Austin, Texas. Interview by Kathy Little, November 10.

____________. 1990. Telephone interview by Mary Ann Kaminski, April 26.

Knitzer, Jane. 1989. "Children with Emotional and Behavioral Problems and the Public Schools: A National Perspective." Paper presented at the Second Annual Conference on Research on Children's Mental Health in Tampa, Florida. (March 1).

Patton, Tom. 1989. Division of Special Education Funding and Compliance, Texas Education Agency, Austin, Texas. Telephone interview by Kathy Little, October 26.

Tex. S. B. 1019, Sec.16.151. 1989. 71st Leg., Reg. Sess.

Texas Education Agency (TEA). 1990. Daily Register of Pupil Attendance, 1989-90. Austin, Texas.

____________. Department of Research and Information. April 1989. Snapshot: 1987-88 School District Profiles. Austin, Texas.

____________. 1989. Memorandum from Commissioner of Education Kirby and TDMHMR Commissioner Jones to Administrators. Subject: "Application for Approval of Noneducational Community-Based Support Services and /or Residential Placement of Handicapped Students (SPE-088R90)." August 18.

____________. June 1989. Report of the Texas Education Agency/ Texas Department of Mental Health and Mental Retardation Joint Task Force on Emotional Disturbance. Austin, Texas.

____________. September 1989. "Special Education Graduates by Handicapping Condition from Senior High Schools." Superintendent's Annual Report--Part Three, Table 1. Austin, Texas. (Computer printout.)

____________. 1998-90. Standard Application System. Instructions for Applications, Amendments, and Final Reports for Special Education Programs. (SAS-101R90) Austin, Texas.

___________. 1990. Regional Service Center Offices. (Map.)

___________. October 1990. "Outcomes of Students with Emotional Disturbance in Residential Placement for Educational Purposes." Texas Education Agency/ Texas Department of Mental Health and Mental Retardation Joint Task Force on Emotional Disturbance. Austin, Texas. (Draft.)

Tex. Admin. Code. Title 19, part II, Ch. 89(g).

Tex. Ed. Code. Sections 16.151(a)(b), 21.503.

Title I--Elementary and Secondary Education Programs Reauthorized (PL 100-297). Chapter 1, Subpart 2, Sections 1221-1226.

U.S. Code Congressional and Administrative News. 100th Congress-Second Session 1988. 1989. Volume 4. Legislative History: PL 100-293 to 100-418. St.Paul: West Publishing Co.

U.S. Department of Education. Office of Special Education and Rehabilitative Services. Division of Education Services and Programs. 1985. Seventh Annual Report to Congress on the Implementation of the Handicapped Act. Washington, D.C.: U.S. Government Printing Office.

Washam, Dan. 1990. Vocational Rehabilitation Counselor, Texas Rehabilitation Commission, Austin, Texas. Telephone interview by Mary Ann Kaminski, January 23.

Yawn, Richard. 1990. Special Education Director, Windham School System, Texas Department of Criminal Justice, Huntsville, Texas. Telephone interview by Mary Ann Kaminski, March 30.

Chapter 3. Texas Department of Human Services

SCOPE OF AGENCY

The Texas Department of Human Services (TDHS) is responsible for administering a multitude of state and federal programs which provide assistance to the poor, the elderly, the disabled, and families and children. The department is governed by a six-member board and employs approximately 14,500 people statewide. Headquartered in Austin, the department operates its programs through 12 regions (ten offices) across the state. In fiscal year 1990, total funding for the department will be approximately $3,841,009,699. Out of this total, $2,416,407,189, or 63 percent, will be provided from federal funds.

The major responsibilities of the department are carried out through the following five programs: (1) Income Assistance, which includes Aid to Families with Dependent Children (AFDC) and the Food Stamp Program; (2) Health Care Services, which primarily involves TDHS's administration of the Medicaid program in Texas; (3) Services to Families and Children, which provides protective services for families and children and various family self-support services, such as employment assistance, child day care, family violence prevention, and family planning; (4) licensing of child care facilities, administrators, and social work practitioners; and (5) Services to Aged and Disabled Persons, which provides a variety of medical and social services, as well as protective services, for aged and disabled individuals.

The importance of TDHS in identifying and serving SED children and adolescents cannot be understated. This is especially true for those children and adolescents who face emotional, physical and sexual abuse. Most of those served by TDHS either in-home or through residential placements are experiencing emotional disturbance or are at high risk of developing emotional disturbance.

LEGISLATIVE CONTEXT OF SERVICES FOR SED CHILDREN

Although TDHS has its formal roots in the early 1900s, the legislative precedent for such a department stems from a March 1848 law enacted in Texas designating apprenticeship as a form of guardianship for dependent and neglected children. In 1907, the Texas Legislature built on that precedent by enacting the Texas Juvenile Act, which defined dependency and neglect and allowed court-appointed guardians of neglected children. The first direct action leading to the department's current structure was the reation of the Child Welfare Division as part of the Board of Control in 1931. The Department of Public Welfare, created in 1939, provided a state-level structure for implementation of the federal Old Age Assistance and Aid to Dependent Children programs, and accepted the Division of Child Welfare from the Board of Control. The department also assisted in determining employment eligibility for persons entering the Works Progress Administration and the Civilian Conservation Corps.

During the next three decades, federal, state, and county participation in services to abused and neglected children increased in uneven increments. In 1962, the Social Security Act of 1935 was amended to require a statewide system of protective services for children. The Texas Family Code, created in 1974, gave the Department of Public Welfare more responsibility for services to abused and neglected, truant, and runaway children. In 1985, the agency adopted the new name, the Texas Department of Human Services.

Today, TDHS is designated as the single state agency in Texas to administer Titles IV, XIX, and XX of the Social Security Act. This act specifies the obligations of Children Protective Services toward Texas Children. Further legal mandates are specified by state laws that require TDHS to protect children from abuse, neglect, or other harm. The Texas Legislature defined abuse and neglect by statute in 1987 in an effort to standardize procedures throughout the state.

In 1987, Section 34.01 of the Texas Family Code was amended to define child abuse and child neglect more clearly. Abuse as defined in the law includes the following acts or omissions by a person responsible for a child's care:

> Inflicting mental or emotional injury to a child that impairs the child's growth, development, or psychological functioning to an observable or material degree;
>
> Causing or allowing the child to be in a situation where the child is mentally or emotionally injured to the point of impairing the child's growth, development, or psychological functioning to an observable or material degree;
>
> Inflicting physical injury that results in substantial harm to the child, or making a genuine threat of substantial harm, i.e. any injury that does not correspond with the history or explanation given. This excludes an accident or reasonable discipline by legally responsible adults that does not expose the child to a substantial risk of harm;
>
> Failure to make a reasonable effort to prevent another person from causing physical injury that results in substantial harm to a child;
>
> Sexual contact or sexual conduct inflicted on a child, shown to, or intentionally practiced in the presence of a child if the child is present only to arouse or gratify the sexual desires of any person.

Neglect includes the following acts or omissions by a person responsible for a child's care, custody, or welfare:

> Leaving a chid in a situation where the child would be exposed to substantial risk or harm without arranging for necessary care for the child and demonstrating an intent not to return;
>
> Placing the child in or failing to remove the child from a situation that a reasonable person would realize requires judgment or action beyond the child's level of maturity, physical condition, or mental abilities and that result in bodily injury or substantial risk of immediate harm to a child;
>
> Failing to seek, obtain or follow through with medical care for the child, with the failure resulting in or presenting a substantial risk of death, disfigurement, or bodily injury or with the failure resulting in observable or material impairment to the growth, development or functioning of the child;
>
> Failure to provide the child with food, clothing, or shelter necessary to sustain life or health of the child. This excludes failure caused primarily by financial inability unless relief services have been offered and refused (TDHS, 1988b, pp. 15-16).

PROGRAM SERVICES

Intake and Investigation

TDHS is mandated by law to investigate reports of suspected child neglect and/or abuse. Upon receiving the initial referral, staff determine the urgency of the situation using priority groups. The following formula determines urgency. Priority I investigations, those involving children alleged or found to be abused or neglected to the extent that they are in immediate threat of serious physical harm or death, are begun immediately or within 24 hours upon receipt of referral. Priority II investigations, wherein children are alleged or found to be abused or neglected but not in immediate danger, are initiated within 10 days. Priority III investigations, children reported to be at risk of abuse or neglect but not actually harmed, are investigated only if there is sufficient staff to do so. In actuality, Priority III investigations are very seldom conducted. Referrals are assigned a priority based upon the information provided by the complaint. Upon investigation, the worker may be unable to confirm that abuse or neglect occurred. Additional information received during the investigation may change the status of the referral. TDHS staff refer all Priority I and II reports to the appropriate law enforcement agency, which determines whether a criminal investigation is warranted. TDHS staff conducts a civil investigation to protect the child from abuse and/or neglect.

The following categories are used to record the findings of child abuse or neglect: (1) Adjudicated--civil or criminal court determines that child abuse or neglect has occurred; (2) Reason to believe--TDHS staff conclude that abuse or neglect has occurred by applying logical reasoning to available information; (3) Unfounded--TDHS staff conclude that abuse or neglect did not occur, or cannot validate that it did occur; (4) Moved--the individuals/family involved in the reported situation have moved and cannot be located.

In-Home Services

When there is a need for continuing protective services, but not enough evidence to remove the child from the home, a plan of service is developed with the family to allow the child to remain in the home. Through in-home services, workers attempt to strengthen the family's ability to focus on problems that contributed directly to the abuse or neglect. When available, community resources, such as family counseling, parenting education, and homemaker services are used to support the family.

Placement Services

When a child's safety is believed to be seriously endangered by remaining in the home, TDHS staff seek court approval to place the child temporarily in substitute care, usually in an emergency shelter or foster family home. During this "emergency period," which is not to exceed 30 days, a determination is made by TDHS staff for placement of the child, which is expected to be in "the child's best interest." If the child needs care which cannot be provided in his or her own home or that of a relative, a level of care is assigned.

The level of care system, which was initiated in 1988, is based upon the needs of the child instead of the provider's type of child-caring license. There are six levels of care (Levels I-VI), with rates of reimbursement for care recommended to the TDHS board by the Health and Human Services Coordinating Council (HHSCC). Each year, a cost analysis questionnaire is mailed to all agencies that contract to provide care for clients of the state. The resulting data are evaluated by the staff of the HHSCC. A median cost is established for each level of care. The board of HHSCC subsequently recommends the daily cost-of-care rates to the state agencies. The board of TDHS then may or may not accept the recommended daily rate for payment to its providers, based on allocated state and federal funds. Presently, TDHS pays the provider of care approximately 82 percent of the median cost of the service for all providers who submitted cost reports and for whom that level of care was the highest they provided.

Table 3.1 displays the current living arrangement, percentages, and numbers of Texas children for whom TDHS is legally responsible. As is indicated, most children in TDHS care are in some type of foster care, but a significant percentage (29.5 percent in August 1987) are living at home or with relatives. Included in this percentage are the children who have returned home from substitute care and are temporarily remaining in the legal responsibility of TDHS "to assure a smooth transition back to the family and community" (TDHS, 1988a, p. 16).

For those children requiring substitute care, the appropriate level of care is determined with the assistance of a two-page behavior rating checklist. The checklist is part of the statewide Common Application packet for placement of children in substitute care facilities. Responses to 11 specific behavioral descriptors determine the level of care. The level of care is selected during the evaluation phase of the intake study (usually during the first 30 days) and is evaluated every six months, or at the request of the provider or TDHS. Placement in a substitute care facility is sought according to the needs of the child and the availability of space in the appropriate facility. The service provider is reimbursed at the rate indicated for a particular level of care as indicated in Table 3.2. It is significant to note that TDHS staff make placement decisions frequently without the services of a psychiatrist, psychologist, or *Diagnostic and Statistical Manual for Mental Disorders* (DSM-III-R) diagnosis.

TDHS has only recently begun to describe behaviorally the more seriously disturbed child (levels IV, V, and VI) in its care. Therefore, many of the descriptors are still roughly defined. There are three key concepts to consider in the assessment of a level IV, V, or VI child:

1. Frequency: How often does the disturbed behavior occur?
2. Severity: How serious is the behavior?
3. Duration: How long has the behavior been going on?

Generally, the greater the level of aggression and destructiveness, the higher the level of care. The following definitions summarize the levels of care system.

In level I, the child can adequately function in all developmental and/or environmental areas. There may be transient difficulties, "everyday" worries, and occasional misbehavior, but the child would be regarded as a "normal" child and responds to normal discipline. The caregiver provides a routine home environment with guidance and supervision to meet the needs of the child.

Level II children have no more than occasional problems in functioning in any area, with some acting-out behavior in response to life stresses, but these are brief, transient, minimally disturbing to others, and not considered deviant by those who know them. The caregiver provides a routine home environment with supplemental guidance and discipline to meet the needs of the child.

Level III children have frequent or repetitive minor problems in one or more areas; they may engage in nonviolent antisocial acts, but are capable of meaningful interpersonal relationships. The child at this level requires supervision in a structured supportive setting with counseling available from professional or paraprofessional staff.

Table 3.1. Children in TDHS Legal Responsibility in 1987 by Type of Placement (N=5,002)

Living Arrangement	Percentage	Total
Own home	15.8	790
Relative's home	13.7	686
Foster care	59.7	2,986
Adoptive home	6.9	345
Other*	3.9	195
Total	100.0	5,002

Source: TDHS, 1988a, p. 16.

*Includes unauthorized absence, detention facilities, hospitals, nursing homes, and independent living.

Table 3.2. Reimbursement Rates for Substitute Care, Effective September 1989

Level of Care	TDHS Daily Rate
Level 1	$ 13.00
Level 2	$ 35.00
Level 3	$ 48.00
Level 4	$ 70.00
Level 5	$ 84.00
Level 6	$121.00
Emergency Care	$ 13.00 - Foster family
" "	$ 48.00 - Foster group home
" "	$ 70.00 - Emergency shelter

Source: TDHS Protective Services, "Reimbursement Rates for Substitute Care," Austin, 1989. (Memorandum.)

Level IV involves substantial problems. These children have physical, mental, or social needs and behaviors that may present a moderate risk of causing harm to themselves or others, poor or inappropriate social skills, or frequent episodes of aggressive or other antisocial behavior with some preservation of meaningful social relationships. They require a treatment program in a structured supportive setting with therapeutic counseling available by professional staff.

Level V children have severe problems and are unable to function in multiple areas. They are sometimes willing to cooperate when prompted or instructed, but may lack motivation or ability to participate in personal care or social activities or are severely impaired in reality testing or in communications. They may exhibit persistent or unpredictable aggression, be markedly withdrawn and isolated due to either mood or thought disturbance, or make suicidal attempts. They present a moderate to severe risk of causing harm to self or others and require 24-hour supervision by multiple staff in a limited-access setting.

Level VI children have very severe impairments, disabilities, and needs, and are consistently unable or unwilling to cooperate in their own care. They may be severely aggressive or may exhibit self-destructive behavior or be grossly impaired in reality testing, communication, cognition, affect, or personal hygiene. They may present a severe to critical risk of causing serious harm to self or others and need constant supervision (24-hour care) with maximum staffing in a highly structured setting.

As indicated, child care providers receive reimbursement fees based on the child's level of care. Reimbursement rates, effective September 1989, are delineated in Table 3.2. These rates are paid to facilities that provide a particular level of care and that meet standards for services for that level.

Adoption

Although most children are returned to their parents or relatives from foster care, for a variety of reasons, some children cannot be returned home. TDHS provides adoption services to children in its managing conservatorship who need adoptive planning regardless of the age or handicap of the child, after the parent-child relationship has been legally terminated. TDHS recruits and studies adoptive homes for these children, places them in approved homes, and supervises the placements until the adoption has been legally consummated. Most of the abused or neglected children waiting for adoption have special problems and special needs. These children are usually older, have emotional, mental, or physical handicaps, belong to a racial minority group, or need to be placed with their siblings. During 1987, 604 children were placed in adoptive homes by TDHS.

In order to expand adoption opportunities, TDHS implemented an adoption subsidy program for special-needs children which includes medical expenses. The goal of the adoption subsidy program is to help alleviate financial barriers related to the special needs of TDHS children who are available for adoption. Subsidies benefit children whose age, race, ethnicity, handicap, or sibling status precludes appropriate adoptive placement. Subsidies assist adoptive parents with the following kinds of expenses when needed:

1. Assistance with the child's food, clothing, and shelter.

2. Fees for services needed by the child. These services include day care, therapy, counseling, extraordinary corrective dental treatment, medical care, equipment, and supplies (TDHS, 1989b, p. 1560).

Generally, to be eligible for a subsidy, a child must meet one of the following criteria at the time of adoptive placement: be six years old or older; be two years old or older and a member of a racial or ethnic minority; have a verifiable professionally diagnosed physical, mental, or emotional handicapping condition; or belong to a sibling group needing placement.

The subsidy paid to the adoptive parents is negotiated on a case-by-case basis and is determined annually. The determination is based on the needs of the child, the child's income (which includes dependent and survivors' income related to the biological family), and the financial ability of the adoptive parents to provide for the child's needs. The maximum amount of subsidy payment may not exceed the cost of foster family care, excluding medical expenses. Presently, foster family care is reimbursed at the level I rate, which is $13.00 per day. In 1989, TDHS paid approximately $5,360,430.00 in subsidies to 2,098 adoptive parents.

As with many facets of protective services, procedures surrounding adoption are being redefined and reformulated by TDHS policy staff and current court proceedings. Among the adoption issues that are being addressed by TDHS and the courts are the following: the efficacy of transracial adoptions, the rights of prospective adoptive parents to full disclosure regarding the child, appropriate recruitment of families for children with special needs, the rights of children, birthparents, and adoptive parents to subsequent reunion, and the need for follow-up services to adoptive families.

The post-adoptive services that TDHS can offer were added by HB 1806, which was passed during the 71st legislative session. The post-adoptive services are designed to support adoptive family functioning by assisting with the periodic and ongoing adjustment to adoption, by treating the effects of abuse in the child's background, and preventing removal of children from the adoptive family setting. The services will not be provided directly by TDHS but through contracts with agencies and individuals that have experience in adoption and postadoption services (Heiligenstein, 1990).

The services that will be available include information and referral, case management and service planning, parent groups, parenting programs, therapeutic counseling services, respite care, residential placement services, and 24-hour crisis intervention. HB 1806 also established the Post-Adoption Services Advisory Committee. The committee will monitor the postadoption services provided and will review the issues concerning adoptees and adoptive families and develop appropriate policy recommendations for the state (Heiligenstein, 1990).

ORGANIZATIONAL CONTEXT FOR SED SERVICES

Because the scope of this paper addresses the severely emotionally disturbed child, only children in levels IV-VI will be discussed. However, statistics are not available for level VI children due to the fact that the level was created in September 1989. It is significant to note that the number of children in out-of-home care in TDHS increased from 5,002 in 1987 to 6,479 in December 1989. This almost 23 percent increase in the number of children in substitute care occurred in spite of a strong emphasis by TDHS to remove fewer children from their homes.

There were over 10,000 children in the conservatorship of TDHS in July 1989. Of the 6,167 children in substitute care, 13.6 percent, or 839 children, were placed in facilities for the emotionally disturbed, which demonstrates a slight decrease from the previous year. Although there are no data on the number of level VI children, TDHS estimates that approximately 10 percent of the 839 children in facilities for the emotionally disturbed would qualify for level VI funding. TDHS received approximately $48 million from the legislature for the 1989-1990 fiscal year for substitute care, but this amount is insufficient to meet present needs. TDHS officials estimate that the agency will need at least $60 million to complete the year at the current level of service. Of this amount, the agency expects to expend $21 million for levels III, IV, and V and $2 million for level VI. Based on TDHS estimated figures for the number of level VI children and the new rate of reimbursement, $2 million is approximately one-half of the amount needed for the year.

There has been speculation that the new category Therapeutic Foster Care might relieve some of the pressure on the service delivery system due to the reduced costs of therapeutic foster care and significant increases in the number of available bed spaces. Although the reimbursement rate is $30.00 a day as compared with amounts approximately three times this size for residential treatment, and although as of December 1989, there were 170 children in therapeutic foster care, the impact on SED children will be felt only indirectly for two reasons. First, by definition, children who are selected for therapeutic foster care will be "those whose degree of emotional disturbance is not severe enough to warrant placement in a residential treatment center and is too great to successfully function in a regular foster home" (Dallas County Department of Human Services, 1989, p. 1). Therefore, by policy statement, SED children have been excluded from the option of therapeutic foster care. Second, according to a TDHS official, only children in levels I-IV can be placed in therapeutic foster care due to the requirements of TDHS licensing standards. For example, children in levels V and VI must be supervised by awake night staff, an option generally unsuitable to a foster home setting. As a result of these factors and other difficulties in the system, there are no level V or VI children in therapeutic foster care. Indirect savings benefits for level I-IV children could provide additional funds for level V and VI children, because therapeutic foster rates are significantly less costly to TDHS than residential treatment facilities.

SOCIAL, PHYSICAL, AND EMOTIONAL EFFECTS OF CHILD ABUSE

Maltreated children experience many harmful physical and emotional consequences of abuse. A joint study committee on treatment of abused children discovered the following concerns in 1989:

Physical effects:

> 60-70 per cent of abused children suffer bruises and welts, skeletal injury occurs in 15-20 per cent of cases, and internal injuries involving brain or neuromotor dysfunction occur in 25-30 per cent of cases.

Emotional and Psychological effects:

> Over 50 per cent of abused children have school-related problems, 22 per cent have learning disorders that require special education services, and abused and neglected children have higher rates of mental retardation. Between 60-80 per cent of adult drug or alcohol abusers have a history of child abuse, abused children have a much higher incidence of suicide and other self-destructive behaviors, and low self-esteem is found uniformly among child victims of abuse and neglect.

Social and Fiscal effects:

> Victims of child abuse are often involved in criminal activities throughout their lifetimes, and society pays an enormous price through the cost of institutionalizing or monitoring the behavior of perpetrators of serious crime (various studies

> indicate that as many as nine out of ten murderers were abused as children). Many victims of physical abuse become physically abusing parents. (TDHS and TDMHMR, 1989, pp. 2.1-2.9).

The costs of treating these effects is astounding. For example, the Texas Department of Mental Health and Mental Retardation (TDMHMR) claims to spend approximately $23,000 per year to maintain one child in the Waco Center for Youth. According to administrative sources, the cost is closer to $55,000 per year. The facility, which serves both TDMHMR and TDHS children, is currently funded to provide care for 78 children. Each agency may place up to half of the institution's population, or 39 children. The Waco center is the only state-supported institution designed to serve emotionally disturbed youth, and it clearly can serve only a very small proportion of the SED children in Texas.

Although it appears that Texas has traditionally resisted prevention programs, many believe that the time has come to improve the present and future lives of abuse victims and save some money in the process. According to the National Council of Juvenile and Family Court Judges, "The long-range costs of failure to prevent, intervene, and treat child deprivation are beyond calculation" (TDHS and TDMHMR, 1989, p. 2.8).

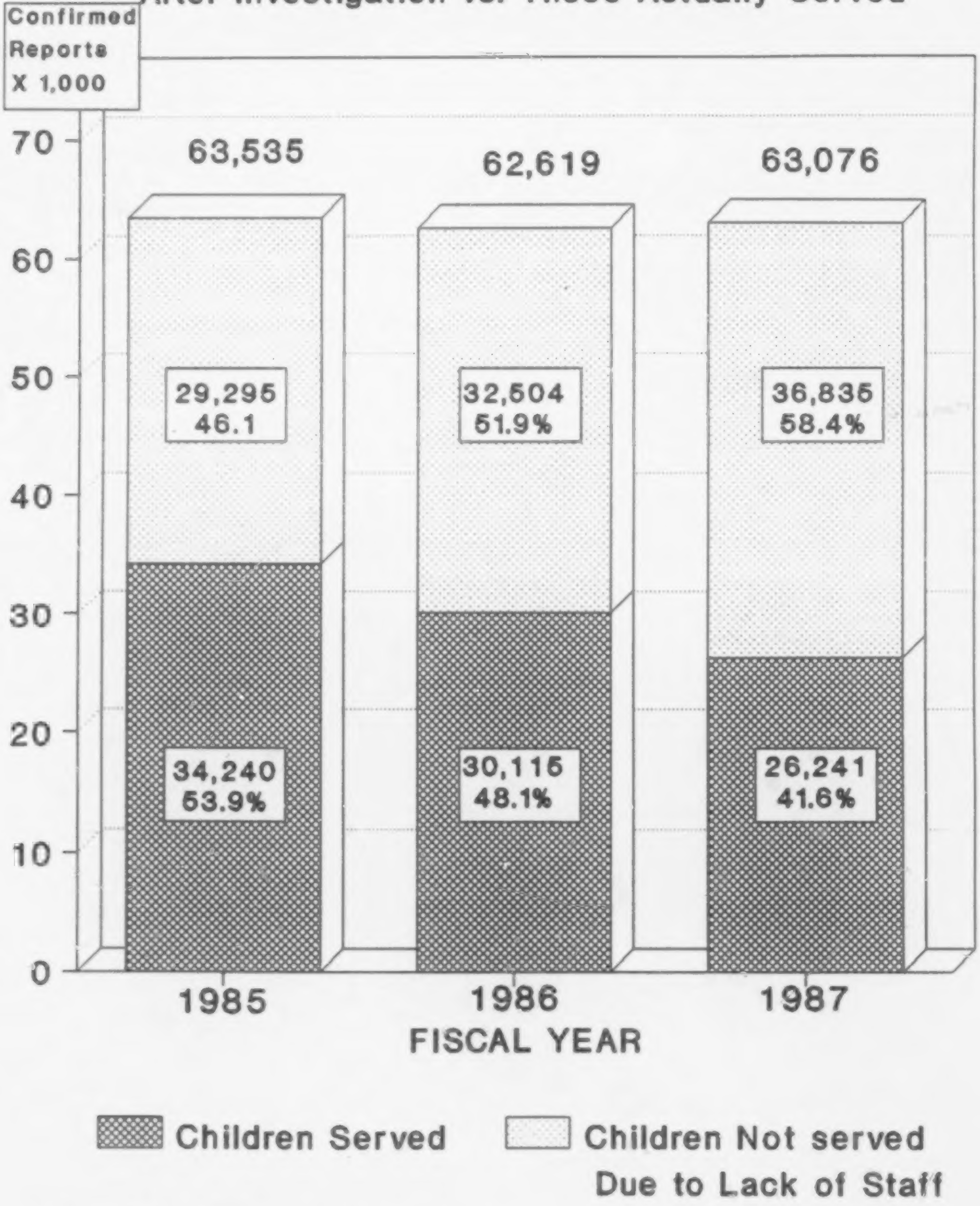
CONCLUSIONS

There are a number of problems which must be addressed by TDHS before the department can work collaboratively with other agencies to meet the needs of the SED child. For example, it appears the system of determining priority at intake leaves much to be desired. First, the time frames from policy directives (24 hours to respond to imminent danger and 10 days to respond to children who are abused but not in imminent danger) provide too much latitude for an adequate response. Second, TDHS serves only a small percentage of cases that need assistance. It estimates that only 70 percent of families in which a report of abuse or neglect is confirmed actually need services. To complicate matters, the state legislature provides funds for TDHS to serve only 70 percent of the total number of families which it believes need services (in 1987, TDHS received funds to serve only 60 percent). The net result is that 49 percent (42 percent in 1987) of the confirmed abuse and neglect cases needing services after investigation are actually served by TDHS. For example, according to the 1987 annual report of Protective Services, there were 63,076 cases of abuse and neglect needing services after investigation (Figure 3.1). Of this number, 26,241 cases, or 41.6 percent, actually received services. The remaining 36,835 cases, or 58.4 percent, received no services. It is no small wonder that both staff and the public are confused about the purpose of TDHS.

Complicating the lack of funds issue is the confusion within TDHS regarding agency philosophy and goals, i.e., child welfare (prevention) vs. protective services (rehabilitation). The American Association for Protecting Children (AAPC) found in 1988 that these differences in philosophy greatly impacted the service delivery system of TDHS. That report concluded that "the decision not to accept Priority III reports (children reported to be at risk of abuse or neglect but who have not actually been harmed) moves Children's Protective Services further away from the area of prevention" (AAPC, August 1988, pp. 3-9).

The in-home services program has also come under fire recently. Although other states have used in-home services to effectively prevent both further abuse/neglect and out-of-home placement, there is confusion among TDHS staff in this area, too. The AAPC findings indicated that "the role of in-home services has not been adequately defined in policy or procedure nor clearly communicated to the broader community, the range of services is inadequate to serve the families who are eligible, and there are no clear

Figure 3.1. Children in Confirmed Reports of Abuse Needing Services After Investigation vs. Those Actually Served



Source: TDHS, 1988a, p. 13.

procedures or uniform guidelines for the development and subsequent review of the service plan by the caseworker and the supervisor" (AAPC, August 1988, pp. 3.17-3.23). In other words, almost anything can be called in-home services.

Other issues which must be confronted include the following:

1. Policymakers should define the SED child in terms that are consistent within TDHS and that can be standardized with other agencies.

2. TDHS should develop a standardized terminology with all agencies in the public and private sector in order to determine the needs of SED children and resources to meet the needs within the state.

3. TDHS should share funds with other state and private agencies in order to best meet the needs of the SED child.

4. TDHS must acknowledge to the legislature the impossibility of predicting the numbers of children, levels of care required, and costs of service for a budget two or three years in advance (a process currently required by the state legislature, which meets every two years).

5. TDHS must improve communication with the Texas legislature in order to address the following issues:

   A. Request sufficient funding from state and federal sources to provide adequate services to the children of the state.

   B. Increase funding to provide 100 percent of cost reimbursement to the provider instead of the present 82 percent.

   C. Develop accurate, understandable statistics for the legislature. Because the level of care system is so new, most statistical inquiries must be answered with "We just don't know."

   D. Establish a relationship of honesty and integrity with the legislature and reduce dependency on the lobbying efforts of TDHS service providers (day care centers, residential treatment facilities, and foster parent associations).

6. TDHS should strengthen intensive family-based services as an alternative to substitute care; this will result not only in significant savings, but also in the preservation of viable family units.

Although it is extremely complex, funds could possibly be increased to purchase better care for SED children through the foster care component of Title IV-E funds of the Social Security Act. Through this legislation, the federal government reimburses the states for the cost of out-of-home care in the following categories: maintenance (payments for a child's room and board), administrative costs associated with running the program, and training. States are reimbursed for maintenance of children in out-of-home care at the same rate as the state's Medicaid match, and administrative costs are federally reimbursed at a 50 percent level. States receive federal funds only on behalf of children who are entitled to Title IV-E, which is approximately 40 percent of all children in out-of-home care nationally (Texas is able to qualify approximately 50 percent). A child's entitlement to Title IV-E funds is related to the family's eligibility for AFDC services.

According to officials at TDHS and the Department of Health and Human Services, Texas is presently receiving the maximum amount of federal dollars in the administrative category. The maintenance, or room and board, category, however, could receive additional funding, if the Texas legislature would appropriate additional state funds. One method of providing more funds is to raise the reimbursement rate to the provider of care from 82 percent to 100 percent of actual cost. According to the funding formula, Title IV-E funds would provide approximately $1.00 for every $3.00 in state money. In light of the current deficit at TDHS, additional state funding seems unlikely. However, the idea could be considered at a later date.

TDHS should also be encouraged to more fully utilize the training portion of Title IV-E. Last year, Texas spent approximately $19,000 in this category while the State of New York utilized $1,000,000. The dilemma once again is matching funds. Matching funds could be considered from outside resources, such as statewide organizations (Texas Networks for Children, Texas Association of Licensed Children's Services, Texas Network of Youth Services, etc.) in order to increase Title IV-E funds for training. Most of these organizations already have annual training conferences. The training should enhance the delivery of services to SED children.

Although Title IV-E funds are presently uncapped, the program was not adequately funded in the appropriation bill for 1989. As a result, Texas and other states haven't been getting their fair share of federal foster care payments. The federal government owes the states more than $400,000,000 in reimbursement funds in Title IV-E from fiscal year 1989, of which $17.4 million is owed the State of Texas. A report published by the Texas Comptroller of Public Accounts it was shown that Texas got about $33 million less in federal foster care than it deserved under its matching rate. In the same year Texas finally got $14 million for payments oringinally due in 1988 (Texas Comptroller of Public Accounts, May 1990, p. 26).

In reality, TDHS (and other state agencies) frequently encounters problems which are outside of its control. For example, TDHS has found itself in the difficult position of being mandated to provide a service without receiving the necessary financial resources to do the job. Frequently it also plays the role of scapegoat. Due to its immense size and its all-encompassing mandates to serve all populations within its jurisdictions, TDHS has no realistic hope of satisfying all the people all of the time. Despite these difficulties, however, TDHS should make efforts to confront these issues to improve services to SED children.

References

American Association for Protecting Children (AAPC). August 1988. A Comprehensive Review of Child Protective Services in Texas. Denver.

Dallas County Department of Human Services. 1989. Therapeutic Foster Care. Dallas.

Heiligenstein, Anne. 1990. Director, Protective Services for Families and Children, Texas Department of Human Services, Austin, Texas. Letter to adoptive parents. (July 17.) (Draft).

Knitzer, Jane, and Elizabeth S. Cole. 1989. Family Preservation Services: The Program Challenge for Child Welfare and Child Mental Health Agencies. New York: Bank Street College of Education.

Texas Comptroller of Public Accounts. May 1990. Dollars We Deserve, Part II: Fixing Federal Policies That Short-Change Texas. A Special Financial Report. Bob Bullock, Texas Comptroller of Public Accounts. Austin, Texas.

Texas Department of Human Services (TDHS). December 1989 and January 1990. Confidential interviews with state office officials. Austin.

__________. 1988a. Protective Services for Families and Children: Annual Report for Fiscal Year 1987. Austin.

__________. 1988b. Region 3-12 Service Guide. El Paso.

__________. 1989a. 1988 Annual Report. Austin.

__________. 1989b. Children's Protective Services Handbook. Austin.

Texas Department of Mental Health and Mental Retardation and the Texas Department of Human Services. 1989. Child Abuse and Neglect: The Impact on Texas Children, Families, and Communities and the Need for Treatment Services. Austin.

Texas Health and Human Services Coordinating Council. 1989. Children and Youth in Texas: A Proposal for Coordinated Services. Austin.

Waco Center for Youth. January 1990 and February 1990. Confidential interviews with Center officials. Waco.

Chapter 4. The Mental Health System for Emotionally Disturbed Children in Texas: Community Mental Health Centers and State Facilities

OVERVIEW

The Texas Department of Mental Health and Mental Retardation (TDMHMR) was created by the state legislature in 1965 as the state authority for public mental health and mental retardation services. This statute, popularly known as House Bill 3, was in response to the 1963 federal Community Mental Health Center Act, which authorized local sponsoring agencies, such as a county, city, hospital, school district, or a combination of these, to establish local, nonprofit community mental health and mental retardation (CMHMR) centers. All of the CMHMR centers contracting with TDMHMR are subject to TDMHMR rules, regulations, and standards for the operation of community-based mental health services.

TDMHMR is organized by mental health and mental retardation program areas. The overall system administration is the responsibility of the TDMHMR commissioner under the direction of the nine-member Texas Board of Mental Health and Mental Retardation, appointed by the governor. The deputy commissioner for mental health has line authority over the regional assistant deputy commissioners for mental health and the superintendents and the directors of the state mental health facilities.

With 28,300 employees and a $1.68 billion FY 1988-1989 biennial budget for mental health and mental retardation services, TDMHMR is the state's largest agency (TDMHMR, September 1989a, p. v). It includes seven state hospitals, four state centers, two specialty institutions for youth, and one forensics facility. It also operates community services through its state hospitals and state centers. Local public mental health services in the more populated parts of the state are delivered through nonprofit CMHCs constituted by local sponsoring agencies or organizational combinations of sponsoring agencies. These sponsoring agencies have taxing authority and appoint the board of the CMHC. For many of their financial allocations to the CMHCs, TDMHMR requires a local match (Lyndon B. Johnson School of Public Affairs, 1990, p. 2).

Since 1967, 35 CMHMR centers have been created. TDMHMR allocates state general revenues, the federal mental health block grant, and other funds to these 35 centers under annual performance contracts for certain services. The collective budget for these centers to cover services for mental health, mental retardation, and substance abuse totaled $276 million in FY 1989; 63 percent of this budget is funded by state general revenue from TDMHMR (TDMHMR, September 1989a, p. v).

This public mental health system provided services to 128,192 adults with mental illness in FY 1989. Of these, 14,171 individuals were served by the state hospitals, 10,715 by the state facility outreach centers, and 103,296 by the community-based services. Table 4.1 shows that community-based mental health services were provided to 15,653 children (age 0-12) and adolescents (age 13-17) in FY 1989. Also 1,538 youth received services at state facility outreach centers, and 1,639 received services at a campus-based facility (TDMHMR, Office of Strategic Planning, April 1990). The demand for both inpatient and community-based services was greater than the ability to serve. Whether formally kept or not, all the services have waiting lists.

Figure 4.1 shows the location of these state hospitals and CMHMR centers as well as other TDMHMR facilities throughout Texas.

Table 4.1. Mental Health Clients Served During FY 1989

State Facility---Community

	0 - 17	18 - 64
MH1[1]	633	6421
MH2[2]	84	790
MH3[3]	411	2490
MH4[4]	378	926
MH5[5]	32	88
	1538	10,715
UNC[6]	160	1,693
MR[7]	21	136

Community Centers

	0 - 17	18 - 64
MH1	5993	51,045
MH2	1875	19,825
MH3	4853	20,485
MH4	2344	9,796
MH5	588	2,145
	15,653	103,296
UNC	263	2,332
MR	2,402	1,276

MH Campus Facilities

	0 - 17	18 - 64
MH1	1311	11,074
MH2	160	1,569
MH3	134	1,130
MH4	31	263
MH5	3	1135
UNC	123	2,500
MR	31	328

Sources: Data were supplied by TDMHMR, CARE SYSTEM, Office of Strategic Planning. Formulae for changing the 6 levels of CARE priority population into the current 5 levels of priority population were supplied by Dr. Vijay

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[1] Chronically dysfunctional mental disorder with present dangerousness and/or dependency.

[2] Historically dysfunctional mental disorder with present dangerousness and/or dependency.

[3] Chronically dysfunctional mental disorder with threat of deterioration to dangerousness and/or dependency.

[4] Dysfunctional mental disorder with threat of deterioration to dangerousness and/or dependency.

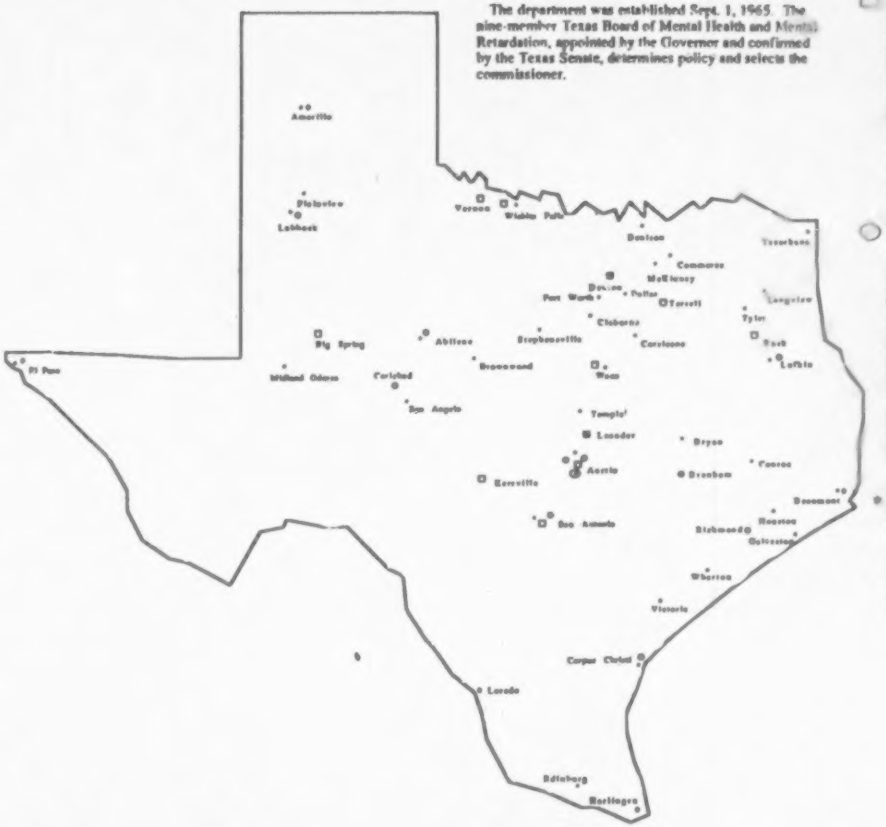
[5] All other persons receiving mental health services.

[6] Persons receiving services who were not classified into a service group.

[7] Persons receiving services at both state school and state hospital during a year.

Figure 4.1 Locations Of State Hospitals, State Centers, And MHMR Centers

The department was established Sept. 1, 1965. The nine-member Texas Board of Mental Health and Mental Retardation, appointed by the Governor and confirmed by the Texas Senate, determines policy and selects the commissioner.


Amarillo
Plainview
Lubbock
Vernon
Wichita Falls
Denison
Commerce
McKinney
Denton
Fort Worth
Dallas
Terrell
Texarkana
Longview
Tyler
Rusk
Lufkin
Big Spring
Abilene
Stephenville
Cleburne
Corsicana
El Paso
Midland Odessa
Carlsbad
Brownwood
Waco
San Angelo
Temple
Leander
Bryan
Conroe
Austin
Brenham
Kerrville
Beaumont
San Antonio
Richmond
Houston
Galveston
Wharton
Victoria
Corpus Christi
Laredo
Edinburg
Harlingen

☐ **MENTAL HEALTH FACILITIES**

These residential hospitals provide intensive therapy services for persons with emotional, alcohol and drug problems. All but Waco Center for Youth operate community outreach services.

Austin State Hospital
Big Spring State Hospital
Kerrville State Hospital
Rusk State Hospital
San Antonio State Hospital
Terrell State Hospital
Vernon State Hospital
Waco Center for Youth
Wichita Falls State Hospital

○ **MENTAL RETARDATION FACILITIES**

These residential schools provide education and training services for persons with mental retardation. Each school operates community outreach services.

Abilene State School
Austin State School
Brenham State School
Corpus Christi State School
Denton State School
Fort Worth State School
Lubbock State School
Lufkin State School
Mexia State School
Richmond State School
San Angelo State School
San Antonio State School
Travis State School

● **STATE CENTERS**

These centers provide day care and short-term residential MHMR services. They operate community outreach programs also.

Amarillo State Center
Beaumont State Center
El Paso State Center
Laredo State Center
Rio Grande State Center, Harlingen

● **COMMUNITY MHMR CENTERS**

Each center, governed by a local board of trustees, provides MHMR services. Many centers operate outreach programs.

Abilene Regional MHMR Center, Abilene
Austin-Travis County MHMR Center, Austin
Bexar County MHMR Center, San Antonio
MHMR Authority of Brazos Valley, Bryan
Central Counties Center for MHMR Services, Temple
Central Plains Comprehensive Community MHMR
Center, Plainview
Central Texas MHMR Center, Brownwood
Collin County MHMR Center, McKinney
Concho Valley Center for Human Advancement,
San Angelo
Dallas County MHMR Center, Dallas
Deep East Texas Regional MHMR Services, Lufkin
Denton County MHMR Center, Denton
MHMR Regional Center of East Texas, Tyler
Gulf Bend MHMR Center, Victoria
Gulf Coast Regional MHMR Center, Galveston
MHMR Authority of Harris County, Houston
Heart of Texas Region MHMR Center, Waco
Hunt County Family Services, Inc., Greenville
Johnson County MHMR Center, Cleburne
Life Management Center, El Paso
Lubbock Regional MHMR Center, Lubbock
Navarro County MHMR Center, Corsicana
Northeast Texas MHMR Center, Texarkana
Nueces County MHMR Community Center,
Corpus Christi
Pecan Valley MHMR Region, Stephenville
Permian Basin Community Centers for MHMR, Midland
Riceland Regional Mental Health Authority, Wharton
Sabine Valley Center, Longview
MHMR of Southeast Texas, Beaumont
Tarrant County MHMR Services, Fort Worth
Texas Panhandle Mental Health Authority, Amarillo
MHMR Services of Texoma, Denison
Tri-County MHMR Services, Conroe
Tropical Texas Center for MHMR, Edinburg
Wichita Falls Community MHMR Center, Wichita Falls

■ **OTHER UNITS**

Genetic Screening and Counseling Service, Denton
Leander Rehabilitation Center, Cedar Park
This recreation and camping center is available to state and community MHMR facilities for client use.

CENTRAL OFFICE

909 West 45th Street, Austin, Texas
Mailing address: P.O. Box 12668, Austin, TX 78711-2668

Source: TDMHMR, Public Information Office, September 1988.

Texas is divided into 63 Local Service Areas (LSAs) (Figures 4.2 and 4.3). For each local LSA, a local Mental Health Authority (MHA) is designated to provide services to children and adults with serious mental illness. Each CMHMR center is the MHA for its respective service area. For those LSAs without a CMHMR center, the regional state hospital or state center outreach serves as the local MHA. This designation of the LSAs and their respective MHAs was designed to enhance accountability and continuity of care through assigned geographic responsibility for consumers' individual treatment and support needs.

The community-based services of the local MHA are the basis for all mental health services that can be provided to the priority population as they enter the mental health system. TDMHMR funding is directed to supply identified core and other services designed to meet the needs of the priority population. Ideally, these services would be provided at the local level unless it is determined that certain needs can be best met at the regional or state level. State facilities are presumed to furnish specialized programs which are not offered locally or regionally as well as serve the most severely mentally ill and behaviorally disturbed youth. In reality, these core services are shockingly lacking at all levels (TDMHMR, Children and Youth Services, March 1990).

TDMHMR's current definition of its priority population is more specifically geared to the adult population. However, according to a draft of the FY 1992-1997 Strategic Plan (TDMHMR, April 1990, p. 10), a proposed new definition of the priority population of children and adolescents with serious mental illness is as follows: "Those under the age of eighteen who have a diagnosis of mental illness or who exhibit severe emotional or social disabilities which are life-threatening or require prolonged intervention."

Several diagnostic categories are associated with serious and long-term mental illness or emotional disturbances in children and youth. They include pervasive developmental disorders, childhood schizophrenia, schizophrenia of adult-type manifesting in adolescence, severe behavioral disorders requiring long-term residential care, and mental retardation and other developmental disabilities with accompanying mental disorders. This priority population definition should also include children and adolescents who are at risk of developing severe emotional disturbances (Lourie and Katz-Leavey, n.d., pp. 4-5).

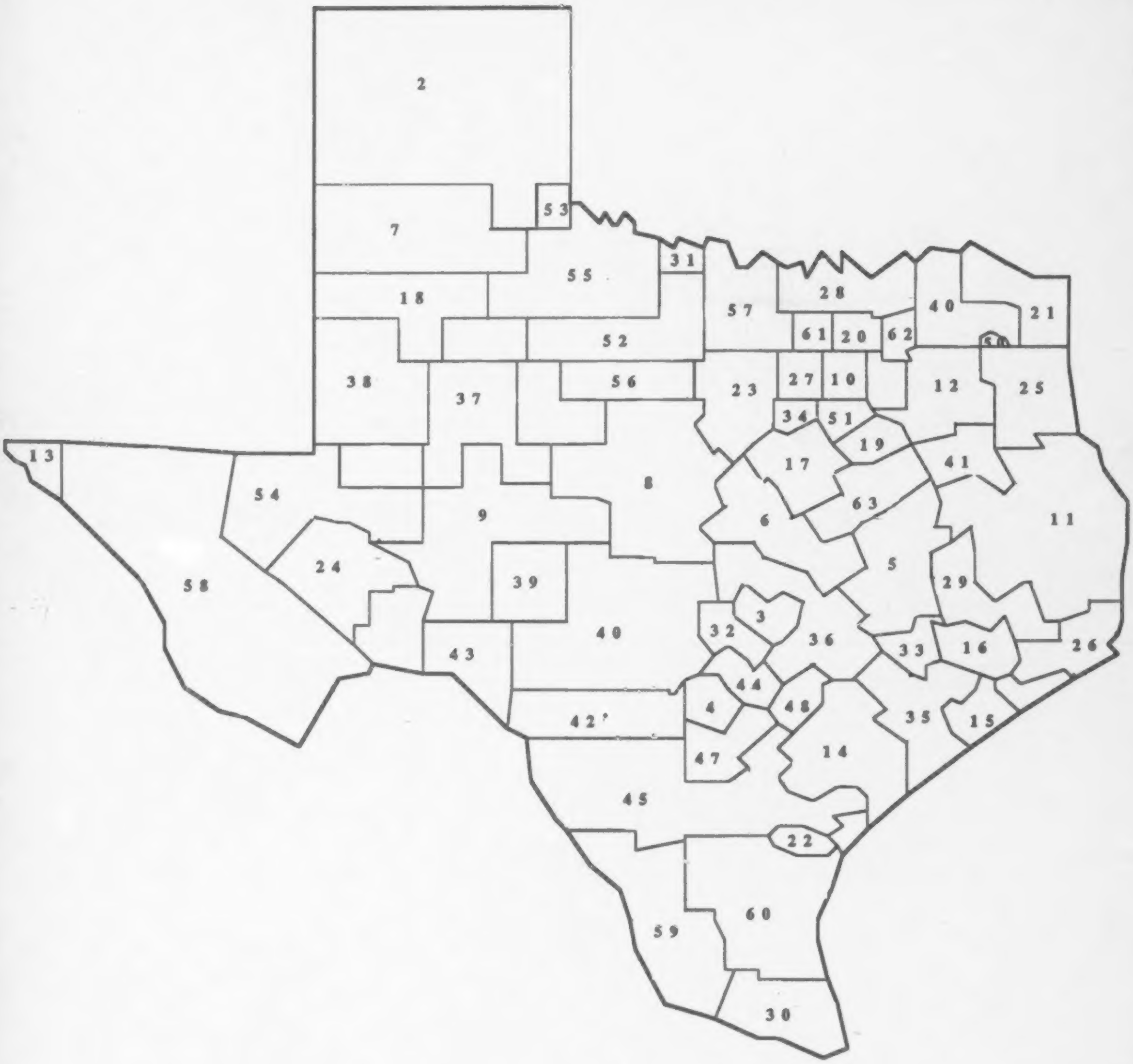
CHILD AND ADOLESCENT UNITS OF THE STATE HOSPITAL SYSTEM

Directly funded by TDMHMR, the State Hospital System of Texas is the main state-operated facility for acutely emotionally disturbed children and adolescents in Texas. As a system, it serves the whole state of Texas, but each of the eight individual hospitals serves populations within the mental health areas which include a number of counties (Figure 4.2).

The child and adolescent units of the state hospitals are the facilities in which Texas youth who are experiencing extreme psychotic episodes or behavioral problems associated with autism are placed. Of the eight state hospitals, six provide services to children and adolescents (Austin and Michie, September 1989, p. 27). The budgets for these child and adolescent units and for Waco Center for Youth for FY 1990 are summarized in Table 4.2.

The average stay for children up to 13 years of age in the Children's Psychiatric Unit of Austin State Hospital is 6.2 months; adolescents between 14 and 18 years of age stay an average of 2.5 months. For FY 1988, for example, the average cost per day for treatment for children and adolescents at Austin State Hospital was $184.00. Altogether 259 children and youths received some inpatient services (Austin State Hospital, Central Office, October 1989).

Figure 4.2 Texas Local Service Areas (LSAs)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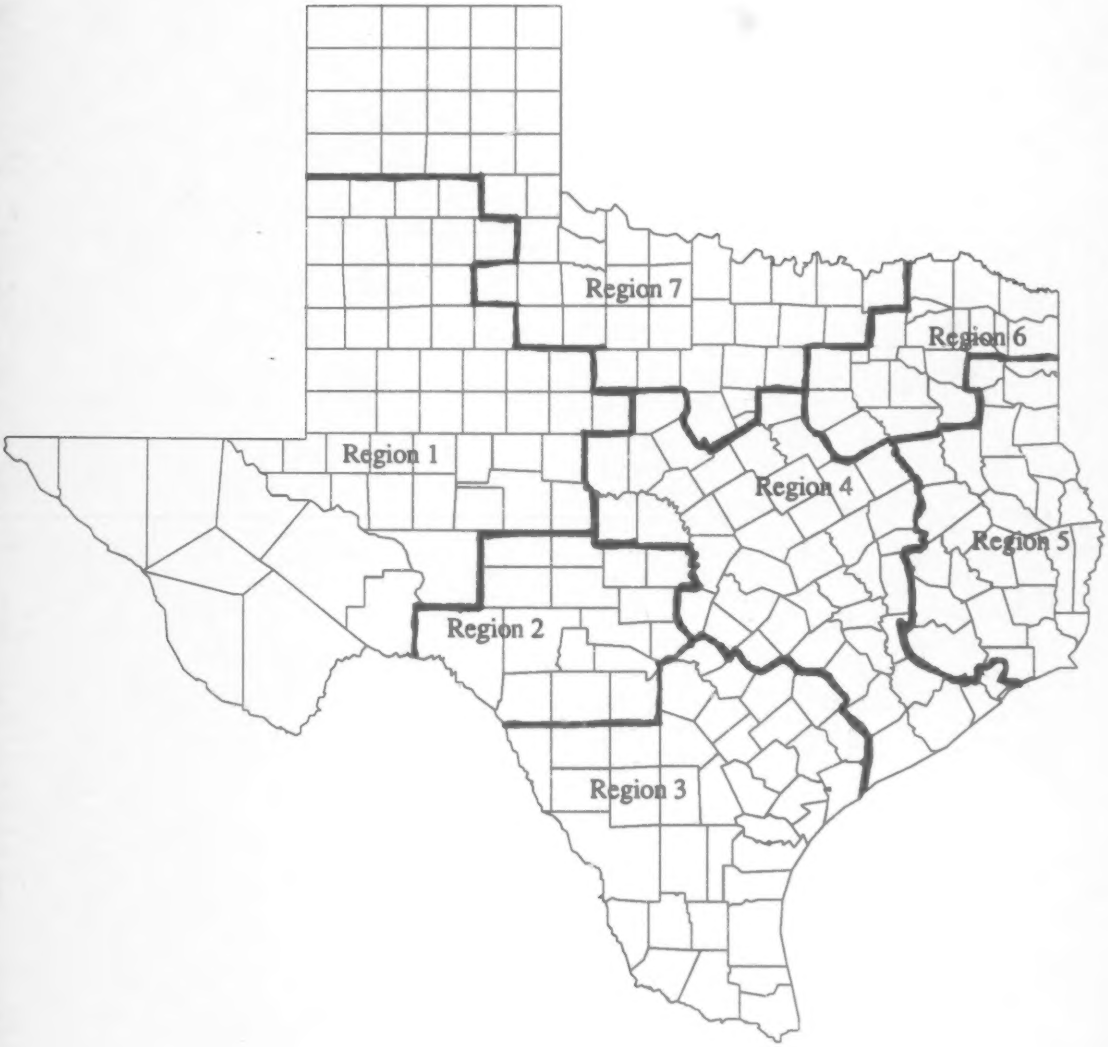
Source: TDMHMR, September, 1989.

Figure 4.3 Mental Health Regions


Region 7
Region 6
Region 1
Region 4
Region 5
Region 2
Region 3

Source: TDMHMR, 1989.

Table 4.2. Budgets for Child and Adolescent Units for FY 1990

[illegible] p. 66

Hosptial	Child/Adolescent Units
Austin	$1,952,344
Big Spring	748,241
Kerrville	-0-
Rusk	-0-
San Antonio	1,119,732
Terrell	1,933,060
Vernon	3,397,284
Waco	2,344,821
Wichita Falls	1,222,570
Total	**12,718,052**

Source: TDMHMR, December 1989.

*Additional expenditures occur, for example, on medical units and via prorated overhead for these individuals.

Specific information on the number of beds for children and for adolescents in each of these facilities is available in Table 4.3. Also shown is information on the number of children and adolescent patients treated at these facilities on a yearly basis.

While Table 4.3 does show that several state hospitals do not have child and adolescent beds, it should be noted that services are available through all state hospitals for child and adolescent inpatient services. These facilities contract with private hospitals for their child and/or adolescent beds. Both Big Spring and San Antonio State Hospitals contract with Southwest Neuropsychiatric Institute in San Antonio to treat their clients who are under 12. Kerrville State Hospital contracts with the same facility for both their child and adolescent beds. Rusk State Hospital contracts with Daybreak Youth Hospital in Beaumont.

As fully secured facilities, state hospitals treat clients whose behavior problems prevent their placement in less restrictive settings. Treatment goals include helping the patients learn to control their own behaviors so they can be placed into other less restrictive settings. For example, if a child at Waco Center for Youth is in need of a more acute-care setting, he or she can be transferred to a state hospital. In other situations, when a child can utilize a more open residential setting, he or she can be admitted from a state hospital directly to Waco Center or another appropriate facility.

The state hospitals provide 24-hour supervision and residential care, diagnosis, stabilization, therapeutic care and treatment, meals, education, physical care, recreation, and training (HHSCC, January 1989, p. 459). Treatment programs include individual and group therapy, behavior modification programs, recreational therapy, and occupational therapy. Psychiatrists, psychologists, social workers, medical personnel, and direct care workers organize individual treatment programs and oversee the clients' treatment. Family participation is included as much as possible in therapy programs.

WACO CENTER FOR YOUTH

Waco Center for Youth (WCY) was created by the 66th Legislature with Senate Bill 463 and was opened on September 1, 1979. Children and adolescents must meet the following admissions criteria:

1. Must be a resident of the state of Texas.
2. Must be diagnosed as emotionally disturbed and admitted through provisions of the Texas Mental Health Code.
3. Must be referred through the Texas Department of Human Services, the Special Education Division of the Texas Education Agency, or the CMHC system.

WCY has statewide service responsibility for seriously emotionally disturbed youth between the ages of 10 and 17. It is located on a 94-acre campus in Waco and provides educational and recreational facilities as well as cottages for daily living. It has the capacity for 78 clients and accepts both males and females. Currently, WCY provides approximately 24 beds for children (age 10-13) and 54 beds for adolescents (age 14-17) and treated 145 Texas youth in the year ending March 1989 (Locklin, Interview, April 26, 1990; Williams, Interview, April 27, 1990) This facility provides psychiatric residential treatment services with an average duration of stay from seven to nine months. No outreach or outpatient services are available.

Table 4.3. Number of Chilren and Adolescents Treated at Each State Facility As of October 1990

Facility	Child Beds	Adolescent Beds	Services Began	Child Patients per year	Adolescent Patients per year
Austin[1]	60	38	1965	90	151
Big Spring	NA*	22	1959	15	105
Harris County[2]	16	40	1957	115	310
Kerrville	NA*	NA*	NA	10	60
Rusk[3]	NA#	NA#	NA	---- 104 ----	
San Antonio	NA*	40	1972	70	200
Terrell	25	60	1965	27	121
Vernon[4]	NA@	156	1974	NA	390
Waco[5]	37	68	1979	---- 145 ----	
Wichita Falls	31	32	1973	35	135

Sources: TDMHMR, September 1989. McKimmey, 1990b.

Notes:

* These facilities contract for their child and adolescent beds with the Southwest Neuropsychiatric Institute in San Antonio.

# Contracts for child and/or adolescents beds at Daybreak Youth Hospital in Beaumont.

@ This facility is designed only for substance abusing adolescents.

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[1] Catchment area includes Harris County.

[2] Acute care primarily.

[3] MHMR Daybreak at Beaumont (does not include Harris County).

[4] Drug dependent youth only with statewide catchment area.

[5] Intermediate care with statewide catchment area.

Clients can be transferred between WCY and state hospitals when necessary. Most of the clients admitted to WCY have a psychiatric diagnosis of "conduct disorder" under the DSM III-R classification system.

Treatment is directly supervised by two staff psychiatrists who oversee a clinical staff including social workers, psychologists, and psychiatric registered nurses. Individual, group, and family therapies are utilized in the treatment programs as well as recreation therapy, occupational therapy, creative therapy, manual arts, and daily living skills. Clients attend school on a daily basis. The on-campus Waco Center for Youth Independent School District allows for the completion of remedial academic work so that clients can reenter public schools within their home communities. Unlike other state hospital facilities, WCY is an open campus--that is, the doors are not kept locked by the staff.

WCY employs an aftercare coordinator, a full-time employee who plans and arranges contacts with community services for all discharged patients. A TDHS liaison worker is also located on site to facilitate referrals, admissions, and discharge plans for all TDHS clients. A full 50 percent of WCY's capacity is reserved for children in TDHS conservatorship who are in need of mental health services.

WCY operates under the same rules and regulations as the state hospitals and in 1982 became accredited by the Joint Commission on Accreditation of Hospitals (JCAH). In order to meet the requirements for JCAH accreditation, the number of nursing staff was increased. This increase, because of budgetary considerations, necessitated the closing of the intensive supervision unit at WCY and led to a reduction in the capacity from 90 to the current 78 beds. As a result of not having an intensive supervision unit, each month WCY turns away numerous youth (one in four) who are inappropriate for the facility because of their aggressive and assaultive behaviors. It is unknown exactly what becomes of these youth. Most are not eligible for commitment to the state hospitals. It is likely that some will not receive the services they need until they commit a crime, are adjudicated, and come to the attention of the Texas Youth Commission. Some of these youth who were inappropriate for WCY, inappropriate for CMHCs, inappropriate for the schools, and inappropriate for their homes become representative, and sometimes literal, systemic casualities. In order to save some of these "inappropriate" youth, interagency collaborations and joint funding of additional staff are being considered as a means of providing quality care for additional children and adolescents at WCY (Hicks, Interview, March 1990).

In response to this need, TDHS committed funds for FY 1991 so that the intensive supervision unit could be reopened. While most of these beds are reserved for adolescents in TDHS conservatorship, the range of treatment which can be offered is now much broader (McKimmey, Intervew, October 12, 1990b).

Professionals and third-party payers are increasingly aware that there is a sub population for whom even repeated moderated stays in inpatient facilities seem to be ineffective. For such children and adolescents it appears that a longer stay in a well-integrated and organized hospital or residential treatment center is appropriate, and many insurers are willing to provide coverage for such care when warranted, even if it is outside the scope of the contract. Similarly there are many children and adolescents who depend on state or agency financing who require long-term care of nine months or more (Edell et al, 1990).

VERNON STATE HOSPITAL DRUG DEPENDENT YOUTH PROGRAM

The Vernon State Hospital Drug Dependent Youth Program (DDYP) opened in March 1974 after the Texas Legislature appropriated the funds in 1971 for a special statewide treatment facility for drug-dependent youth. TDMHMR selected Vernon as the site of the treatment facility because it is remote from the metropolitan drug scene. DDYP is a secured facility with a controlled perimeter. The south campus of the then two-year-old Vernon Center underwent extensive renovations before its opening, and now houses young people from 13 through 21 years of age who have substance abuse disorders.

DDYP will consider for admission those adolescents residing in Texas who must obtain treatment as a voluntary condition of probation; have been abusing drugs and are in need of hospitalization and treatment; and have exhausted all community treatment resources for drug abuse, including being screened by the appropriate mental health authority. Prospective patients diagnosed as being mentally retarded or as having a psychosis such as schizophrenia are not eligible.

Individualized treatment programs include group and individual psychotherapy, Alcoholics Anonymous/Narcotics Anonymous activities, occupational and recreational therapies, vocational rehabilitation, educational and daily living skills training, as well as psychiatric and medical services. The staff's goal is to discharge a person capable of drug-free and acceptable social, vocational, and recreational living.

Patients generally stay at the facility for four to six months to complete the therapy program. Costs for DDYP are prorated on a sliding fee scale based on family size and income. Upon discharge, the patients are referred to a community agency near their homes for follow-up care.

While at DDYP, a patient may earn high school or college credits, obtain a GED certificate, develop vocational skills, or do remedial work at the appropriate grade level. The high school academic program is administered by Vernon High School. Credits earned can be applied toward high school graduation at Vernon High School or the high school in the person's home community. College credits are available through correspondence courses with accredited universities.

Family involvement is stressed in aftercare, and counseling is strongly encouraged for families of all patients. Social service staff work closely with patients to arrange for family counseling during the patients' stay at DDYP and later in aftercare.

COMMUNITY MENTAL HEALTH AND MENTAL RETARDATION CENTERS

The community mental health center movement began under the Kennedy administration when federal funds were provided to promote community mental health through the 1963 Community Mental Health Center Act. The act bypassed the state by allocating funds directly to the local community centers and their boards. This launched the CMHMR center as the local component of the mental health system, even though no direct definition of its basic function was provided. The Reagan administration redirected these funds and consolidated them with other health programs in 1981, and states continue to receive mental health block grant funds, even though the amounts have declined relative to costs. From FY 1982 to FY 1987, the block grant appropriations increased only 16 percent, which is 9 percent below what CMHMR centers received in 1981 (Lyndon B. Johnson School of Public Affairs, 1990b, p. 3). As federal money has been reduced over the last decade, the centers have become increasingly more sensitive to state priorities, which translates into providing care at the community level to persons who before would have been in a state hospital. This approach has resulted in the recent shift of mental health populations from state facilities to the community.

The local CMHMR centers receive a portion of their funding from TDMHMR, but because their role in community mental health services is mandated by law and because federal dollars have been reduced, a "patchwork" funding situation has resulted in which local centers spend much of their time looking for money to fund their programs. Contract funding (for example, through TDHS), small grant awards, and training grants are examples of the kinds of supplemental funding used.

It is a popular conception that state hospitals serve as facilities for long-term placement of chronically ill patients who may never be able to live in the community. However, as a result of the settlement of the class-action suit R. A. J. v. Jones, CMHMR centers may receive incentive payments if they reduce their utilization of state hospitals below predetermined days per thousand population. The suit was filed against all Texas state hospitals on behalf of all past, current, and future state hospital patients. As a result, minimum staff-to-patient ratios were ordered to provide for safe conditions and effective treatment for state hospital patients. In order to comply with this court order, funds that would have been used to hire more staff were transferred to the CMHMR center programs. TDMHMR started the so-called $35.50 program in September 1984 to provide incentives to community-based programs to reduce the utilization of state hospital beds by providing services to clients who would have otherwise been placed in a state hospital. It was believed that this would reduce the staff-to-patient ratio in the state hospital without the financial burden of hiring extra staff. By implementing this program, an incentive to treat clients in the community was provided, and funds to the CMHMR centers were expanded (Lyndon B. Johnson School of Public Affairs, 1990b).

However, the R. A. J. v. Jones suit further depleted funds for youth services. Rather than providing for more care in the facilities and communities, this suit actually diverted available funds from children's programs to chronically mentally ill adult services (Sutton, 1990, p. 8). At the time of this lawsuit, the state was also pressured by a downturn in the economy, and oil revenues were not available as a cushion for spending needs. This lack of adequate funding for staff has resulted in the loss of valuable trained personnel at all levels of TDMHMR.

Children's services in particular pay a big price in the funding battle for CMHMR centers. In the past there has been no line item in the TDMHMR budget for child and adolescent services at these centers, so these programs often were, and still are, the ones to pay the price during these budget battles. Current operating budgets for CMHMR centers, as shown in Tables 4.4 and 4.5, reveal this lack of funding for youth services. Administrators are often forced to spend much of their time in search of funds. Treatment programs and community services suffer because of the lack of readily available funds for these centers.

Table 4.5 shows the special line item for children and youth demonstration projects. This $2 million for the FY 1990-1991 biennium will be used for four demonstration projects at the Dallas County MHMR Center, Austin-Travis County MHMR, Sabine Valley Center, and Rio Grande State Center Community Services. A more thorough discussion of these projects can be found in discussion of Major CASSP Efforts in Chapter 11.

The proportion of community services for children and adolescents continues to be very limited when compared with community services for adults. Comprehensive services for child and adolescent patients rarely have been implemented. In 1989, 100,534 youth in Texas were expected to require public mental health services (TDMHMR, September 1989b, p. 64). Figure 4.4 documents these assertions. As noted earlier, 18.7 percent, or 18,830 youth, actually received services (Table 4.1).

All of the 35 CMHMR centers, 7 state hospital outreach services, and 3 state centers are required to provide core services to their clients. However, many centers often fail to provide adequate services for children and adolescents. The children's services that do exist are primarily on an outpatient basis. A recent unpublished analysis of a TDMHMR Key Informant Survey demonstrates startling gaps in the continuum of care for the youth

Table 4.4. Operating Budgets of the CMHMRCs for Fiscal Year 1990

Mental Health Services
Contracted Community Services by Center

	1989 Expended (Est)		1990 Recommended	
Centers	**Clients**	**Dollars**	**Clients**	**Dollars**
Abilene	1,400	1,023,752		1,117,209
Austin-Travis	6,395	3,068,900		3,487,403
Bexar County	9,420	6,046,311		6,645,290
Brazos Valley	1,641	1,688,133		1,906,122
Central Counties	4,800	1,792,222		1,973,720
Central Plains	1,750	784,798		860,869
Central Texas	1,295	806,708		868,784
Collin County	1,298	1,436,945		1,631,655
Concho Valley	685	756,276		845,655
Dallas County	11,255	10,388,038		11,654,261
Deep East Texas	2,500	1,752,324		2,248,663
Denton County	1,375	1,252,873		1,425,441
East Texas	3,653	1,267,879		1,672,298
Gulf Bend	2,411	803,842		1,071,072
Gulf Coast	1,950	2,965,829		3,443,933
Harris County	14,211	12,239,412		13,996,506
Heart of Texas	1,876	1,708,801		1,886,483
Hunt County	1,124	581,057		629,984
Johnson County	500	621,389		725,352
Life Management Center	5,835	3,357,989		4,018,670
Lubbock	2,688	1,401,572		1,593,276
Navarro County	909	300,882		328,535
Northeast Texas	1,175	602,563		788,108
Nueces County	3,589	2,246,291		2,433,093
Pecan Valley	1,658	1,196,699		1,301,718
Permian Basin	1,860	1,976,694		2,241,123
Riceland	732	842,947		2,204,221
Sabine Valley	6,619	1,744,067		1,945,276
Southeast Texas	6,000	3,503,645		4,371,414
Tarrant County	12,921	4,847,414		5,737,943
Texas Panhandle	3,050	2,052,920		2,289,362
Texoma	1,890	1,081,475		1,177,665
Tri-County	2,345	1,722,840		2,154,051
Tropical Texas	5,075	4,688,472		5,340,322
Wichita Falls	1,745	886,605		977,524
Subtotal, Centers	**127,630**	**83,618,564**		**96,993,001**
Mental Health Incentive Program		17,685,819		18,392,168
Contingency Reserves				100,000
Homeless Block Grant		1,724,504		1,161,353
Total, Contracted Community Centers	**127,630**	**103,028,887**		**116,646,522**

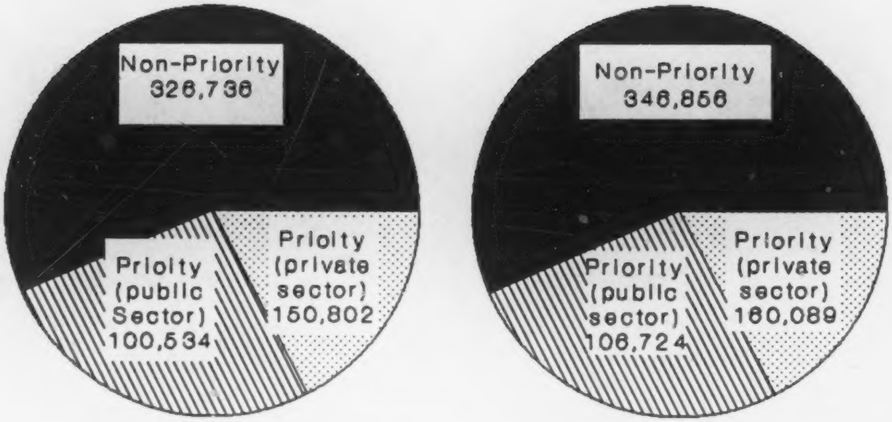
Source: TDMHMR, September 1989, p. 24.

Table 4.5. Operating Budget for Child and Adolescent Mental Health Services

	FY 1990	FY 1991
Child and Adolescent Services	$500,000	$1,500,000
Methods of Finance		
State Funds		
General Revenue	500,000	1,500,000
Federal Funds		
Other Funds Est.		
Total, Method of Finance	**$500,000**	**$1,500,000**

Source: TDMHMR, September 1989, p. 26.

Figure 4.4. Needs of Children and Adolescents With Mental Problems in Texas



1988

(Total Population Aged 0-17 = 5,026,714)

1993

Total Population Aged 0-17 = 5,336,251)

These data are based on National Institute of Mental Health state mental health planning guidelines.

Source: TDMHMR, April 1990.

of Texas. Of the 38 MHAs studied (data were not available for the remaining 7), only 9 centers report having case management services; 7 centers report provision of substance abuse therapy; and just 2 centers offer child/adolescent day treatment programs. These and other results of this analysis underscore the alarming lack of appropriate child and adolescent services (TDMHMR, Children and Youth Services, March 1990).

With the contract funding situation as it is, the agencies that pay for MHMR services are granted priority for treatment. This leaves most community referrals at a loss for adequate care, although emergency situations are often not turned away (Gonzalez, Interview, October 1989).

In 1988, TDMHMR received a grant from the National Institute of Mental Health to begin a Child and Adolescent Service System Program (CASSP). CASSP's main purpose is to assist states in developing a coordinated community-based system of care for severely emotionally disturbed children. In order to accomplish this, CASSP has set the following program goals:

1. Improve the availability of continuum of care for severely emotionally disturbed children/adolescents at the community level.
2. Establish interagency coordination mechanisms and increase levels of collaboration, and ultimately efficiency of service delivery, among agencies.
3. Develop leadership capacity and increase priority for funding of resources for child and adolescent mental health services at both the state and community level.
4. Develop family participation in the planning and development of service systems, treatment options, and individual service planning.
5. Assure that service system development takes place in a context that is responsible to the special needs of culturally diverse ethnic minority groups.
6. Develop the capacity for child and adolescent service system development and provide technical assistance.
7. Evaluate the principles and practices of CASSP (Hicks, Interview, October 1989).

Also involved in the planning process of providing mental health services to children and adolescents is the Child and Adolescent Service System Program Advisory group. This is a subcommittee of the Children and Youth Services State Coordination Committee (CYSSCC). The objective of the CASSP Advisory group is to provide overall direction and coordination of children's services and to help facilitate the planning of child and adolescent services for the TDMHMR system. It was formed to enhance the development of adequate and appropriate mental health services for children and youth on a local, regional, and statewide level.

A new age of recognition of the importance of services for children and adolescents may be arriving. The Texas legislature recently appropriated $2,000,000 for the FY 1990-1991 biennial budget for TDMHMR. This money was designated for children's services in urban, mixed urban/rural, and rural areas. CASSP was authorized to define and solicit requests for proposals for the use of these funds (TDMHMR, September 1989b, p. 81).

This money was appropriated through Senate Bill 222, Article II, Section 11-64, which states:

> CHILD AND ADOLESCENT SERVICES. Funding appropriated in Item 5.e., Child and Adolescent Services, shall be utilized to provide community mental health services for children and adolescents defined in the priority populations and for children and adolescents defined by the Texas Department of Mental Health and Mental Retardation as being at high risk of developing severe mental illness. Monies from Item 5.e. appropriated during the biennium shall not supplant the fiscal year 1989 level of funding expended by each community mental health center for mental health services for children and adolescents, but shall be in addition to it. The Texas Department of Mental Health and Retardation shall develop incentives to encourage community mental centers to expand community mental health services for children and adolescents.

A total of $1,750,000 in grants were awarded to sites in each of four categories based on youth population. The remaining $250,000 was used in a matching joint grant with the Texas Juvenile Probation Commission. All five of the funded projects emphasize interagency coordination, parent support and involvement in service development and treatment, home and school-based services, and case management. The demonstration sites will be monitored and their services evaluated in order to identify, develop, and replicate effective home-based child and adolescent services in the community. Chapter 11 of this volume provides more detailed information on these demonstration projects.

Contributing to the new recognition for the need for child and adolescent services are other recent legislative mandates. House Bill 2116 calls for interagency training for the staffs of the main five child-serving agencies. According to the mandate, the Texas Department of Human Services, the Texas Department of Mental Health and Mental Retardation, the Texas Youth Commission, the Texas Juvenile Probation Commission, and the Texas Education Agency will adopt a joint memorandum of understanding to develop a training program, curricula, and site selection for the training and selection of experienced professionals to lead the training. This memorandum is currently in development and the planning process for the training is underway.

As a result of yet another legislative mandate (Article V, Section 83 of the General Appropriations Act), the Health and Human Services Coordinating Council was required to develop a standardized payment rate, monitoring procedures, and common applications to be utilized for all children and youth placed in contract residential care. The MHAs are being encouraged to use the Common Application for each MHMR client referred for placement in contract residential care. In addition to simplifying client transferrals, information in the Common Application will be analyzed as part of an interagency research study on the effectiveness of the level of classification system used in the application.

Finally, Senate Bill 1697 requires that TDMHMR provide core services for children based on available resources. These services include multidisciplinary assessments, family support programs (including respite), crisis intervention/stabilization, 24-hour emergency screening and referral, psychosocial rehabilitation programs, case management, and medication-related services. The core services are currently underfunded and their implementation is at a stage far below the needed capacity, as evidenced by the results of the Key Informant Survey.

Together, these grants and mandates should expand services to the severely emotionally disturbed youth of Texas and their families. Slowly, components for a truly client-centered, family-focused, community-based system of care may be put in place.

RECOMMENDATIONS

In dealing with severely emotionally disturbed children, it must be recognized that many youth in Texas have multiple needs. All available resources must be considered in planning services for children and adolescents. Collaborative and cooperative relationships must be developed to focus on the individual needs of Texas youth rather than on the traditional or historical manner in which services have been delivered. To be effective, TDMHMR must provide a system of care for children and adolescents which encompasses a holistic approach with all of the following characteristics:

> An integrated system of child-serving agencies in a comprehensive continuum of services which respond to a child's physical, emotional, social, and educational needs, and to include the education, juvenile justice, child welfare, health, and substance abuse agencies.
>
> A system sensitive to the effects of social, economic, cultural, and ethnic forces on child and youth development.
>
> A system which, at the state and community level, incorporates flexibility in funding, decision-making, service delivery, and structure to ensure responsiveness to children and adolescents as their needs change. (TDMHMR, September 1989a, p. 65).

Clearly, with the added push of legislative mandates, the time is right for increased attention to mental health services for children and adolescents. It is time for the citizens of Texas to choose to make young people a priority. It is time to take bold strides toward a comprehensive continuum of mental health services for the children of this state.

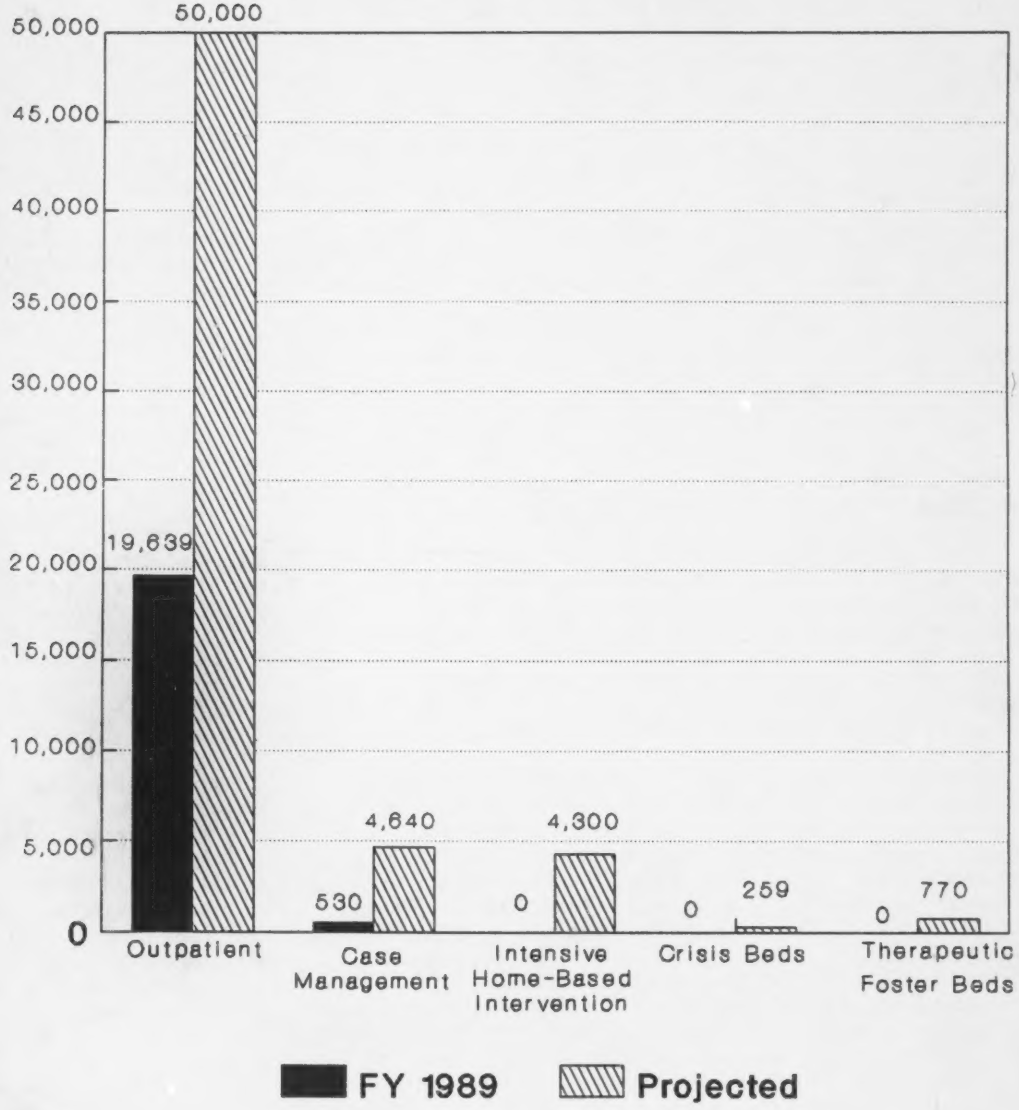
To begin such a venture, it is first necessary for all of the child-serving agencies to arrive at a mutual understanding of "severe emotional disturbance." In order to provide care to severely emotionally disturbed youth, it is imperative that those individuals who need services be identified. One possible action to increase accurate identification of those who need services is to acknowledge 2 percent of the total school population as the standard rate for prevalence of emotional disturbance in school-age children. This estimate complies with PL 94-142, and each school district would be monitored for compliance and would document its attempts to screen the population that may be in need. A routine screening procedure could be conducted in the schools, much like the routine testing for academic skills achievement. This screening procedure could aid in earlier identification of children with mental health needs. School districts could also provide assistance to the juvenile justice and child protection service systems in identifying and obtaining treatment for the seriously emotionally disturbed children under their jurisdiction (TDMHMR, September 1989a, p. 78).

After identification of who the clients are, the question of where to serve them follows. Children generally spend at least one-third of their time at school, so the schools seem to be an obvious location for beginning treatment.

What types of services should be offered? Legislative mandates have partly answered this question. In order to be in compliance with the law, all core services for children must be provided at the community level. Special attention should be directed to the increased availability of day treatment services, crisis stabilization, respite care, and case management services. (Figure 4.5 illustrates the current and projected number of children served by selected mental health services.)

Friedman (1984, pp. 12-13) noted that day treatment services are less costly, just as effective, and less restrictive than residential services. Given this information, one

Figure 4.5. FY 1989 vs Projected Number of Children to be Served by Selected Mental Health Services



Source: TDMHMR, April 1990, p. 13.

recommendation is to increase the availability of day treatment services. Joint funding between the school districts and the CMHCs could make this feasible. School-based day treatment programs available in each school district could reduce the number of youth placed in residential services outside of their home communities, increase funding for other services by reducing the amount spent in residential treatment centers, and still be as effective as the residential treatment centers, if not more so (Friedman, 1984, p. 12).

Case management services are an integral component in any system of care. The present lack of resources demands creativity in the utilization of those resources which are available. Case managers are the creative members in the continuum of care; in a sense, they create their own resources. The primary agency for each child with multiagency needs could supply the case coordination services.

Crisis stabilization is a vital ingredient in the comprehensive array of services. Having a 24-hour emergency crisis stabilization placement is essential for families with severely emotionally disturbed children. Currently there are a few such placements available for the older youth population but none for the children under 10 years of age (Moore, Interview, April 24, 1990). Related to the need for crisis stabilization services is the need for respite care. Families with severely emotionally disturbed children are often under an inordinate amount of stress. Providing respite care might well eliminate potential crises by acting as a pressure release valve for the child and for his or her family.

Texas has only 3.2 public residential beds for emotionally disturbed children per 100,000 population, which is less than half the national average of 7.2 beds per 100,000 population. Other populous states, such as California, New York, and Pennsylvania, have 9 or more beds per 100,000 population (TDMHMR, September 1989a, p. 78). Even though day treatment services have been shown to be as effective as residential services in treatment outcomes, some adolescents have sufficiently involved situations which demand short-term residential placement. More public residential beds should be made available, perhaps through pooled fundings from the involved agencies.

In light of the extremely aggressive or assaultive youth who has been deemed "inappropriate" for services in his or her own CMHC, school, WCY, or foster care but who has not yet become definitively involved with the juvenile justice system, appropriate services must be provided. An intensive residential program, specifically for these youths, must be incorporated into the existing system of care. One possibility is that every agency which could not provide services for the child could participate in the joint funding necessary to pay for the needed services. Clearly, children are not inappropriate for services; rather the services available are inappropriate for the needs of the children.

Service boundaries among agencies often become barriers to consumers and their families. Families with multiagency needs frequently feel overwhelmed and frustrated by the maze of seemingly unconnected services. Coordination of resources and creativity in resource management are essential for the improvement of services for severely emotionally disturbed youth and their families. Better integration of the services of the various agencies is needed to form a tight, deliberate interagency system. Through the interagency memoranda of understanding which foster cooperation and eliminate bureaucratic barriers, this integration is slowly proceeding. Still, more complete collaboration is needed to close the cracks of the system in order to provide children at risk a more complete service system. Interagency collaboration can be increased through heightened awareness of the roles and responsibilities of other agencies, the assessment tools of other agencies, as well as the intervention and case coordination approaches used by other agencies. In addition, a representative from each agency could be designated as a cooperating member of an Interagency Council for each LSA.

Another solution in the armamentarium of possibilities is to increase family involvement in the child's treatment program. Viewing the parents/guardians as peer professionals and seeking their perspectives for service strategies for their child is essential for effective, long-lasting treatment. Increasing the family's knowledge of advocacy could be a giant step in public, and eventually legislative, awareness.

Of course, funding is always a question when services are mentioned. A short-range answer would be perhaps through in-kind contributions; a long-range answer would be through increased legislative appropriations specifically for the mental health needs of children and adolescents.

In-kind contributions could take many forms. For example, each school district could contribute an office and support staff within one school per district; each of the five child-serving agencies could contribute a staff person and his or her office needs (desk, chair, phone, etc.). Together these agency representatives, children and families, and others as needed (pediatricians, for example) could form a Multi-Agency Service Team (MAST) within each school district, serving the needs of the identified children with mental health needs in that district. In-kind contributions could also include joint funding of placements. If a child without financial resources needed to be placed in a residential treatment center for a specified period of time, the agencies involved with that child could contribute equal monies for the placement.

The analysis of the Key Informant Survey demonstrated that there are startling gaps in the community-based systems of care for severely emotionally disturbed children and adolescents. In addition to the information presented earlier in this chapter, other glaring deficits in children's mental health services are evident. Only 3 of the 38 centers interviewed report providing sexual abuse counseling; less than half (15 of the 38) report offering individual therapy; only 7 offer group therapy (TDMHMR, Children and Youth Services, March 1990). This neglect of children is shameful; however, inadequate funding usually results in insufficient services. If these services were comprehensively available through agencies other than the CMHMRCs, this lack of activity would not be so serious. In fact, for the population dependent on publicly funded services, there is little evidence that in most areas of the state that they are available at all routinely.

Texas ranks 48th among the states in expenditures per capita for mental health services. If expenditures were to double, Texas would still spend less per capita than 14 other states. To rank 26th, or average, Texas would need to increase expenditures by 60 percent (TDMHMR, April 1990, p. 4). Children receive a smaller proportion than adults of this already depleted amount of funds. In 1988, the total mental health budget for Texas was $285,585,595. Of this budget, only 13.5 percent was allocated to patients 0 to 17 years old, an age group which makes up about 33 percent of the total population (Sutton, 1990, p. 7).

In FY 1989, 18.7 percent or 18,830 children of the 100,534 estimated who need public services received mental health services, as noted earlier. Projections for 1990 estimate that 101,776 youth will need public mental health services (Table 4.6). To serve just half of these youth (50,888), Texas must more than double its current efforts. The cry from all agencies is to increase state funding. This increase could be through the use of a pool of monies which could only be accessed through interagenacy coordination and collaboration for youth with multiagency needs. A more grandiose possibility is to increase budget line items to cover the total cost for children's mental health services. According to McKimmey (1990a), the cost of statewide implementation of a comprehensive continnum of care would be $ 474,316,050 (Table 4.7). Receiving even half of that amount for children's services would be a vast improvement to the current situation.

Table 4.6. Estimated 1990 LSA Youth Population (Age 0-17) Compared to FY 1989 Persons Served by Community-Based Services

State Hospital Programs	Region	Local Service Area	1989 Estimated* Total Population	1990 Estimated* Youth Pop. (Ages 0 - 17)	Percent of State Youth	1990 Estimated** Youth Needing MH Services	1990 Estimated*** Youth Needing Public MH Services	Served FY 1989**** Community-Based TDMHMR Services
Kerrville-Region 2		39,40,42,43	192,042	58,100	1.14%	6,682	1,162	160
San Antonio-Community		44,45,47,48	474,531	129,023	2.54%	14,838	2,580	Included in Region 3
Big Springs-Community		37,38,54	271,320	79,905	1.57%	9,189	1,598	Included in Region 1
Austin-Community		32,33,36	356,200	101,857	2.00%	11,714	2,037	Included in Region 4
Rusk-Community		41	97,625	27,292	0.54%	3,139	546	Included in Region 5
Terrell-Community		49,50,51	289,451	82,227	1.62%	9,456	1,645	Included in Region 6
Wichita Falls-Community		[illegible],53,55,56,57	156,495	47,176	0.93%	5,425	944	Included in Region 7
SUBTOTAL			1,837,664	525,580	10.33%	60,442	10,512	160
State Centers								
El Paso	1	58	23,425	6,996	0.14%	805	140	Included in Region 1
Laredo	3	59	185,548	70,960	1.39%	8,160	1,419	Included in Region 3
Rio Grande	3	60	104,614	33,505	0.66%	3,853	670	Included in Region 3
SUBTOTAL			313,587	111,461	2.19%	12,818	2,229	
Mental Health Centers								
Abilene	1	1	167,127	46,322	0.91%	5,327	926	
Central Plains	1	7	105,183	35,460	0.70%	4,078	709	
Life Management	1	13	584,094	201,987	3.97%	23,229	4,040	
Lubbock	1	18	280,952	82,307	1.62%	9,465	1,646	
Concho Valley	1	9	125,863	34,879	0.69%	4,011	698	
Permian Basin	1	24	289,650	89,920	1.77%	10,341	1,798	
Region 1 SUBTOTAL			1,552,869	490,875	9.65%	56,451	9,818	1,687
Bexar County	3	4	1,169,911	359,056	7.06%	41,291	7,181	
Gulf Bend	3	14	172,963	50,590	0.99%	5,818	1,012	
Tropical Texas	3	30	667,003	257,372	5.06%	29,598	5,147	
Nueces	3	22	321,599	102,750	2.02%	11,816	2,055	
Region 3 SUBTOTAL			2,331,476	769,768	15.13%	88,523	15,395	3,027
Austin-Travis	4	3	545,587	135,974	2.67%	15,637	2,719	
Central Counties	4	6	302,308	92,448	1.82%	10,632	1,849	
Central Texas	4	8	104,729	27,477	0.54%	3,160	550	
Gulf Coast	4	15	431,989	126,468	2.49%	14,544	2,529	
Heart of Texas	4	17	234,931	63,149	1.24%	7,262	1,263	
Brazos Valley	4	5	252,754	66,359	1.30%	7,631	1,327	
Riceland	4	35	331,379	102,801	2.02%	11,822	2,056	
Johnson County	4	34	89,927	26,134	0.51%	3,005	523	
Region 4 SUBTOTAL			2,293,604	640,810	12.59%	73,693	12,816	2,844

Table 4.6 (Continued). Estimated 1990 LSA Youth Population (Age 0-17) Compared to FY 1989 Persons Served by Community-Based Services)

State Hospital Programs	Region	Local Service Area	1989 Estimated* Total Population	1990 Estimated* Youth Pop. (Ages 0 - 17)	Percent of State Youth	1990 Estimated** Youth Needing MH Services	1990 Estimated*** Youth Needing Public MH Services	Served FY 1989**** Community-Based TDMHMR Services
Southeast Texas	5	26	381,920	106,149	2.13%	12,437	2,163	
Sabine Valley	5	25	308,516	89,871	1.77%	10,335	1,797	
Deep East	5	11	333,131	106,861	2.10%	12,289	2,137	
Harris County	5	16	3,044,916	875,577	17.21%	100,691	17,512	
Tri-County	5	29	333,159	99,540	1.96%	11,447	1,991	
Region 5 SUBTOTAL			4,401,642	1,279,998	25.15%	147,200	25,600	6,384
East Texas	6	12	295,765	80,047	1.57%	9,205	1,601	
Northeast Texas	6	21	131,613	37,574	0.74%	4,321	751	
Dallas County	6	10	1,827,414	484,450	9.52%	55,712	9,689	
Navarro County	6	19	40,304	10,908	0.21%	1,254	218	
Hunt County	6	62	67,986	16,796	0.33%	1,932	336	
Region 6 SUBTOTAL			2,363,082	629,775	12.38%	72,424	12,596	3,494
Panhandle	7	2	381,432	112,987	2.22%	12,994	2,280	
Tarrant County	7	27	1,092,242	286,515	5.63%	32,949	5,730	
Wichita Falls Center	7	31	133,108	35,221	0.69%	4,050	704	
Texoma	7	28	152,596	38,443	0.76%	4,421	769	
Pecan Valley	7	23	147,436	38,282	0.75%	4,402	766	
Denton County	7	61	195,708	57,197	1.12%	6,578	1,144	
Collin County	7	20	214,514	71,898	1.41%	8,268	1,438	
Region 7 SUBTOTAL			2,317,036	640,543	12.59%	73,662	12,811	2,367
TOTAL STATE YOUTH				5,088,810	100.00%	585,213	101,776	19,963

Source: Texas Department of Mental Health and Mental Retardation, Strategic Planning, March 1990.

Data Sources

* Texas Department of Health Population Estimates

** Based on 11.5% general rate, Assessment of Needs of Children and Adolescents with Mental Health Problems in Texas, TDMHMR, April 1984.

*** Based on 2%, Toward A Model Plan for Comprehensive Community-Based MH System, October 1987 (99-660).

**** CARE, TDMHMR, Open cases 9-1-88 to 8-31-89. Includes state facility community services. Add 21 unclassified by region.

Table 4.7. Proposed Budget for a Statewide Implementation of a Community-Based, Comprehensive Continuum of Care

Services*	Needed Slots*	Average Cost/Slot**		Cost/Block***
Assessment	120	$ 400	/child	$ 48,000
Med-Related	60	$ 1,200	/year	$ 72,000
Home-Based	20	$ 2,638	/treatment	$ 52,760
Ther. Foster Care	8	$ 84	/day-365 days	$ 245,280
Day Treatment	20	$ 42	/day-365 days	$ 306,600
Substance Abuse	20	$ 1,560	/year/child	$ 31,200
Case Management	40	$ 2,000	/year/child	$ 80,000
Crisis Resolution	1	$ 295	/client/day	$ 107,697
Total Per Service Block				$ 943,537

The total number of service blocks is equal to the total child/adolescent population in Texas divided by 10,000. (5,026,714/10,000) = 502.7 services blocks) There are 502.7 service blocks in Texas. At $943,537 for each service block, the total cost for statewide implementation is $474,316,049.90.

This model for projecting costs for creation of a comprehensive mental health system for children was developed in North Carolina in the mid 1980s. North Carolina has been in the forfront of mental health delivery for children and adolescents and used five years experience in developing the model. It is based on 1) determining overal state need, 2) estimating costs for needed services, and 30 developing a plan for incremental implementation. This model projects costs based on a formula for the number of "slots" needed in each treatment component in the system per a certain population. For example, the Model projects the need for 40 case management slots per each population group of 10,000 children and adolescents.

For the purposes of this document, need has been determined by utilizing the figure of 100,534 identified in the PL 99-660 Plan (TDMHMR, September 1989), based on NIMH guidelines. Incidence projections for this population range upward to 11 percent. The 100,534 figure is 0.0198 percent of the child/adolescent population, a miniman incidence figure, lower than other accepted estimates.

Source: McKinney, 1990.

Notes:

* Information provided by the North Carolina Model of comprehensive Care.

** Average cost was established through the average of the costs in several mental health centers in Texas.

*** Needed slots times average cost per slot equals the cost per service block.

Naturally, these solutions alone will not be effective at eradicating the problems caused by years of neglect of children's mental health issues, but a combination of these possible solutions could go far in establishing a viable, healthy future for the youth of Texas.

CONCLUSION

Despite lack of adequate funding and a dearth of appropriate services, Texas has moved forward in the planning and development of mental health services for children and adolescents. Through the various grant proposals and legislative mandates, TDMHMR has taken its first steps toward an integrated and appropriate array of youth services. Without dollars, resources, or creativity, the often neglected nonvoting children's constituency will continue to be overlooked and underserved. Many steps are needed before this journey is finished and comprehensive community-based services for severely emotionally disturbed children and adolescents are a reality.

References

Austin, D., and I. Michie. September 1989. Community Resource Intervention Notebook. Austin, Texas. (Draft.)

Austin State Hospital, Central Office. October 1989. Austin, Texas. Telephone interview by Paul Crabtree.

Edell, William S, Ralph E. Hoffman, Stephen DiPietro, and Diane F. Harchrick. 1990. "Effects of Long Range Psychiatric Hospitalization for Young, Treatment Refrectory Patients." Hospital and Community Psychiatry, July, pp. 780-785.

Friedman, R. 1984. "Seriously Emotionally Disturbed Children: An Underserved and Ineffectively Served Population." Tampa: Florida Mental Health Institute.

Gonzalez, J. October 1989. Bexar County Mental Mealth and Mental Retardation Center. Telephone interview by Paul Crabtree.

Hicks, R. March 1990. Coordinator, Children and Youth Services, Texas Department of Mental Health and Mental Retardation. Interviewed by Tracy Levins.

____________. October 1989. Coordinator, Children and Youth Services, Texas Department of Mental Health and Mental Retardation. Interviewed by Paul Crabtree.

Locklin, C. 1990. Director, Waco Center for Youth. Telephone interview by Tracy Levins, April 26.

Lourie, I., and J. Katz-Leavey. n. d. "Severely Emotionally Disturbed Children and Adolescents."

Lyles, J. 1989. Vernon State Hospital. Correspondence to Paul Crabtree, September 28, 1989.

Lyndon B. Johnson School of Public Affairs. 1990a. Financing Community Care for the Chronically Mentally Ill: Four Case Studies in Texas. (Fall 1990, Policy Research Project Report No. 89.) Austin, Texas.

Lyndon B. Johnson School of Public Affairs. 1990b. Financing Care for the Chronically Mentally Ill in Texas. Austin, Texas. (Forthcomming).

McKimmey, G. 1990a. "Projected Budget for Statewide Implementation of a Community-Based, Comprehensive Continuum of Care." Austin, Texas. (Draft.)

____________. 1990b. CASSP Director, Texas Department of Mental Health and Mental Retardation, Austin, Texas. Interview with Nicholas Hoover, October 12.

Moore, L. 1990. Director of Psychological Services, Austin Child Guidance Center. Interviewed by Tracy Levins, April 24.

Sutton, B. 1990. "Psychiatric Hospitalization of Children and Adolescents."

Texas Department of Mental Health and Mental Retardation (TDMHMR), Office of Strategic Planning. April 1990. "Number Served by Age and Type of Facility." Austin, Texas. (Computer printout.)

____________. April 1990. Strategic Plan: FY 1992-1997. Austin, Texas. (Draft).

____________. Children and Youth Services. March 1990. "Key Informant Survey." Austin, Texas. (Computer printout, Draft.)

____________. Management Analysis and Reporting Unit (MARU). September 1989. "Number of Child and Adolescent Beds per Facility." Austin, Texas. (Computer printout.)

____________. September 1989a. Future Directions for Comprehensive Community Based Mental Health Services in Texas. Austin, Texas.

____________. September 1989b. FY Operating Budget. Austin, Texas.

Texas Health and Human Services Coordinating Council (HHSCC). January 1989. Health and Human Services in Texas: A Reference Guide. Austin, Texas.

Williams, J. 1990. Director, Waco Center for Youth. Telephone interview by Tracy Levins, April 27.

Chapter 5. Texas Juvenile Probation Commission

The Texas Juvenile Probation Commission is only one aspect of the juvenile justice system in Texas. The entire juvenile justice system is made up of county juvenile probation departments, county juvenile probation boards, county judges designated as juvenile judges, the Texas Youth Commission (TYC), and the Texas Juvenile Probation Commission (TJPC). These agencies and their staffs work together to keep communities safe, to help juvenile offenders through treatment in the least restrictive setting, and to prepare those juvenile offenders to be returned to their community. Many of the youth in the juvenile justice system have emotional problems, although they are not labeled emotionally disturbed or severely emotionally disturbed. Some youth who have obvious problems may be referred to other agencies, while others are placed in residential treatment or back in the home. Following is a detailed description of the TJPC's function in the juvenile justice system and a description of what is being done for youth within the system who show signs of emotional problems.

DESCRIPTION OF THE TEXAS JUVENILE PROBATION COMMISSION

General Mandate

The Texas Juvenile Probation Commission was established in 1981 by the Texas Legislature to:

1. give state aid to county juvenile probation departments,
2. improve the effectiveness of probation services,
3. provide alternatives to the commitment of juveniles to TYC,
4. establish uniform standards for services and detention facilities, and
5. improve communications between local and state services (TJPC, 1988a, p. 2).

In 1981, there were 50 counties without juvenile probation departments. These counties would commit all juvenile offenders to TYC as wards of the state. Now there are many programs to keep youth from having to be committed to TYC, and all counties have some juvenile probation services (TJPC, 1988b, p. 4).

Administrative Structure

The TJPC is a statewide coordinating agency for the 156 juvenile probation departments and 191 juvenile boards which serve all Texas counties. The actual Texas Juvenile Probation Board is made up of nine members, appointed by the governor, who guide the TJPC staff of 22 employees. Two members of the board must be judges of district courts, one must be a county judge or commissioner, and the remaining six members must be Texas citizens who are not employed in the criminal or juvenile justice system. Their terms are six years and staggered. The TJPC administration consists of an executive and deputy executive director, general counsel, a financial officer, an administrator of contracts, a director of reports and statistics, a training director, a systems analyst, an auditor and accountant, several program specialists, and clerical support.

By law, there is also an Advisory Council on Juvenile Services, which is appointed by the TJPC. This advisory council consists of two juvenile judges, three juvenile probation officers, two citizens knowledgeable of juvenile services, and representatives of the Texas Youth Commission, the Texas Education Agency, and the Texas Department of Human Services. This advisory council helps determine juvenile justice policy.

At the county level, the administrative structures vary according to the size and the needs of the community, but there is a juvenile board in every county. The boards are responsible for setting policy for the juvenile probation departments, and these boards receive funding from the county commissioners court and the TJPC. Texas is the only state that has juvenile boards. Other states are looking at this system with interest (TJPC, 1988b, p. 2). In other states the juvenile judge is in control of the system and the quality of services depends upon the interest and administrative skill of that judge.

Some communities in Texas also set up advisory boards. These boards help to identify resources in the communities such as volunteers and money to run special programs. The boards typically serve as a liaison between the juvenile justice system and entities in the community such as advocacy groups, schools, and volunteer organizations. Further, the boards may lobby the county commissioners for policy changes, new programs, or additional funds.

Overall, the juvenile probation departments are quite diverse throughout the state. For example, in Dallas County, a psychology division is part of the department as a result of the need to assess the mentally ill/mentally retarded and emotionally disturbed children brought into the system. Other counties (Travis County, for example) rely on psychological examination done through the educational system. Some probation departments (49 out of 156) have only one staff member, and 31 counties combine the adult and juvenile probation departments (TJPC, 1989d, p. 7). Altogether, there were 1,411 juvenile probation officers serving the 8,293 juveniles on probation throughout Texas in 1988 (TJPC, 1989d, pp. 7 and 16).

Budget

The budget of the TJPC from 1986 to 1991 is shown in Table 5.1. In 1988, state aid made up 16 percent of county funding, local funds made up 79 percent, and the Criminal Justice Division of the Governor's Office made up the remaining 5 percent. Total funds spent on juvenile probation in 1988 were $74,682,795 (TJPC, 1989d, p. 8).

Counties have been increasing their juvenile probation spending by a total of $4,000,000 per year since 1981 while state funds have remained almost the same, up until FY 1990-1991, when there was an increase in the state budget of almost 50 percent (TJPC, 1988b, p. 12).

According to a study conducted by the TJPC, the cost of providing minimal service for an average referral in 1986 was $824. In FY 1986, only $685 per referral was available (TJPC, 1988b, p. 12). For 1988, the Texas Legislature figured the cost per referral to be $906 (using a 10 percent increase per year from the 1986 figure). The total funds available were $74,682,795 in 1988, and there were 70,721 referrals, making the amount of money available per referral $1,056. Although these figures seem to show that there was more than adequate funding for 1988, two other considerations must be taken into account. First, this year saw a great deal of expansion with the building of new detention centers and the adding of more beds, which was quite expensive. Second, despite the legislature's 10 percent increase in the estimated cost per referral, a review of costs in the 15 largest counties in Texas showed the cost to be $1,146 per referral in 1988 (Logan, Interview, January 11, 1990).

Table 5.2 shows the statewide average costs per day per client served by the TJPC according to the different services provided by the local probation departments. The most expensive service shown is the detention centers because of the cost of building, maintaining, and staffing them. Contract placements are also very expensive. Foster care is the least expensive form of placement outside of the home, but usually no treatment or rehabilitation occurs in foster homes. Informal adjustment and direct placement

Table 5.1. Texas Juvenile Probation Budget

BUDGETS FOR 1986-1989

	Expended 1986	Expended 1987	Expended 1988	Budgeted 1989
Administration	1,021,983	882,601	916,713	939,877
State Aid	12,232,415	10,767,990	11,858,754	11,931,848
Challenge Grants	0	0	446,502	745,125
TOTAL	13,254,398	11,650,591	13,221,969	13,616,850

REQUESTS / APPROPRIATIONS FOR 1990-1991

	Requested		Appropriated	
	1990	1991	1990	1991
Administration	975,169	972,169	957,628	956,128
State Aid	15,039,600	15,039,600	14,931,848	14,931,848
Challenge Grants	1,500,000	2,000,000	1,122,563	1,372,563
Community Corrections	6,100,000	7,900,000	3,050,000	3,950,000
Family Focused Contract Svcs.	1,500,000	1,500,000	0	0
TOTAL	25,114,769	27,411,769	20,062,039	21,210,539

Sources: Texas Sunset Advisory Commission, 1986, p. 15; Legislative Budget Board, 1989, p. I-120; Tex. S.B. 222, 1989, p. I-237.

Note: All money comes from the General Revenue Fund. There are 22 employees with the TJPC.

Table 5.2. Average Costs per Day per Client

Service	Cost in FY 1988
Detention	
State	$13.26
Local	64.74
Total Cost	$78.00
Contract Placement	
State	$ 6.29
Local	30.71
Total Cost	$37.00
Foster Care	
State	$ 2.82
Local	12.87
Total Cost	$15.69
Informal Adjustment*	
State	$ .54
Local	2.65
Total Cost	$ 3.19
Direct Probation Supervision*	
State	$ .54
Local	2.65
Total Cost	$ 3.19

Source: TJPC, 1989b, p. 5.

*Costs for detention, contract placement, and foster care are figured by average cost per child per day times the number of days in placement. These costs were then subtracted from the FY 1988 expenditures. The remaining costs were divided among the categories of informal adjustment and direct probation supervision using a formula developed by the TJPC. These other costs include expenditures for transportation of juvenile, delinquency prevention, public education/awareness, school liaison and truancy services, drug, alcohol and inhalant abuse services, volunteer services, child advocacy and referral services, unofficial referral work, work with TYC and parolees, and public relations. Costs are computed as state-wide averages and differ among departments according to the level of local funding.

supervision encompass a wide variety of services depending upon the needs of the child. These services are explained in detail in the next section of the chapter.

JUVENILE PROBATION PROGRAMS AND SERVICES

Texas Juvenile Probation Commission Services (State Level)

Support Services. The TJPC assists county juvenile probation departments by providing training and certification of probation officers, providing technical assistance and legal advice, monitoring local department activities, and maintaining and reporting statistical data on juvenile activity in Texas.

Prevention Services. Part of the philosophy of the TJPC as stated in its 1987 annual report is to put more resources into preventing juvenile delinquency. The reality is that few if any of the TJPC dollars are spent on prevention. Instead, prevention is left to Child Protective Services (Rudeseal, Interview, October 6, 1989). One reason is that the TJPC has jurisdiction only of children 10 to 17 years old, whereas CPS serves children under 10. There seems to be a "turf" issue between the two agencies which keeps them from working together effectively on prevention issues (Rudeseal, Interview, October 6, 1989). Another reason is that the money for prevention is just not available. To divert money away from other programs could mean the difference between a current juvenile offender being placed in a treatment center or being sent back home without treatment. The TJPC does, however, encourage local communities to develop prevention programs. Whether these preventive programs exist is now entirely dependent upon the county juvenile probation departments and their budgets.

Challenge Grants. In 1987, the TJPC received appropriations totaling $500,000 ($446,502 was actually used) for the delivery of services to children with multiple problems and needs (TJPC, 1989c, p. 19). This Challenge Grant program disburses the funds to individual counties to be spent on children who are delinquent and are abused, neglected, mentally ill, mentally retarded, or emotionally disturbed. The first juveniles were served beginning in October 1987 by nine juvenile probation courts. In 1988, 170 juveniles were placed by the Challenge Grant program. These juveniles would otherwise have been committed to TYC or would have received minimal services. The funds must be used for direct placement costs, direct placement services, or nonresidential services. Nonresidential services include psychological, psychiatric, and other professional diagnostic, evaluation, and treatment services; medical and dental diagnosis, evaluation, treatment, and supplies; vocational and educational fees and supplies, related programs, services, supplies, and tutoring not provided by public schools; transportation and meals; clothing and personal hygiene supplies; and other nonresidential services related to the objectives of the program if approved by the TJPC (TJPC, n.d.).

The FY 1989 budget total for the Challenge Grants was $1,480,248; half came from the state and half from the participating counties since the funds require a dollar-for-dollar match from the counties. The counties which are currently participating in the program include Bexar, Brazos, Dallas, El Paso, Hidalgo, Jefferson, Lubbock, Tarrant, Taylor, and Travis. The program has received an increase in funding for FY 1990 and 1991. Appropriations for FY 1989, 1990, and 1991 respectively are $745,125; $1,122,563; and $1,372,563. Table 5.3 summarizes the FY 1989 allocations and placements by county for the Challenge Grant program.

Juveniles who have received services through Challenge Grants are 11 to 17 years old, but mostly over 13; 74 percent are male and 26 percent female. Most are mentally ill and/or abused and neglected, but some are mentally retarded. Usually these juveniles have committed several offenses, and without the resources from the grant, most would have been committed to TYC. Some are runaways, substance abusers, and/or thieves. Generally

Table 5.3. Challenge Grant Interim Report for 1989

County	FY '89 Budget	No. of Children in Placement	Placement Days
Bexar	$192,000	15	2,293
Brazos	113,208	14	1,966
Dallas	233,708	25	4,084
El Paso	173,708	21	3,319
Hidalgo	20,000	10	510
Jefferson	123,708	31	3,401
Lubbock	149,708	22	3,886
Tarrant	184,000	18	2,758
Taylor	107,708	17	2,758
Travis	132,000	10	1,860
TOTAL	1,480,248	183	26,635

Source: Rudeseal, Interview, October 6, 1989.

Note: These figures are based upon reports received as of September 26, 1989. The budget figures for each department are the total of state and local funds, and reflect two adjustments made during the year. These adjustments were made to ensure that more funds were made available to the departments most in need of them.

these juveniles have the following personality characteristics: aggressive and uncontrollable behavior, low self-esteem, and depression (TJPC, 1989b, p. 17). Challenge Grants are funds devoted to helping youths who are typically a challenge to the juvenile justice system because of their multiple needs. Challenge Grant money is basically the only state money going to the county juvenile probation departments which must be spent on a specific population; otherwise, localities have discretion over funds.

Foster Care. At the state level, the TJPC originally had a foster care program to enhance local foster care programs. But as cutbacks were made in the 1985 budget, this program lost its resources (TJPC, 1988b, p. 12). The TJPC encourages counties to develop their own foster care programs because in comparison with other placements foster care is inexpensive. In 1988, 32 counties were operating foster care programs at an average cost of $16 per day per child. Contract placements averaged $37 per day per child (TJPC, 1988a, p. 5).

The Border Children Justice Project. The Border Children Justice Project, which operates in cooperation with Mexican government officials, was created to provide more humane and cost-effective services to juvenile offenders who are citizens of Mexico (TJPC, 1988a, p. 15). In 1988, 55 Mexican juvenile offenders were diverted from commitment to TYC through this program at an approximate cost of $117,000 (TJPC, 1989d, p. 17). The juveniles are either taken back to Mexico or are placed on probation in Texas when appropriate. The program originated as a result of significant increases in Mexican youth committed to TYC. In 1985, 5 percent of all commitments to TYC were Mexican alien students, which cost the state $2.1 million. Since 1985, when the Border Children Justice Project was begun, the commitments of Mexican youth to TYC have been greatly reduced (TJPC, 1988b, p. 11).

Community Corrections. The Community Corrections program works at keeping juveniles closer to their homes when placed in residential treatment centers. This is a new program which first received funding for FY 1990. Another program which was proposed (but did not receive funding) during the past session of the legislature was Family Focused Contract Services. This program would have spent more resources on aiding families and is discussed more in the current issues section.

Intensive Supervision Programs. Intensive supervision, a relatively new effort begun in April 1988, diverts more youth from TYC. Juveniles in this program are typically supervised with more frequent visits to the probation officer and with an electronic monitoring device attached to the juvenile's leg. Twenty counties are currently using this program (TJPC, 1988a, p. 16).

Services Provided by Probation Departments (County Level)

Intake Function. At a local level, the juvenile probation departments have an intake function which determines whether a child would benefit from detention, legal proceedings, referral to a social service agency, placement in a residential treatment center or foster home, or counseling by the juvenile probation department staff members (TJPC, 1989d, p. 16). Intake (probation) officers are also responsible for preparing court reports to present to the juvenile judge or court referee. In some cases, the intake officer also determines whether a youth needs medical, dental, or psychological treatment. The juvenile probation department will typically contract these services for juveniles needing them. This basic intake function does vary somewhat from county to county depending on the size and budget of the department. Among other things, 47 probation departments do not have the funds available to put juveniles in residential placements (TJPC, 1988d, p. 8).

In the larger counties, there may be a psychology division or a single psychologist within the probation department who assesses a juvenile to determine whether the juvenile is mentally ill or emotionally disturbed or whether there are other signs that the child may have problems. The psychologists use levels of care guidelines, DSM III-R guidelines, and/or the school system's guidelines for those who are seriously emotionally disturbed. The psychologist will then determine whether the juvenile's home is an appropriate place for treatment. A few counties provide a family training program, a family therapy program, and other psychological services. Smaller counties will typically refer emotionally and mentally disturbed juveniles to other agencies if they detect a problem.

Youth are brought into the juvenile probation departments by police, social service agencies, parents, schools, TYC, and others. In 1988, 100,016 youths between the ages of 10 and 17 were arrested in Texas, but of those arrested, 36,329 were warned and released, diverted, or tried in criminal court for Class C misdemeanors (meaning they never were referred to the juvenile probation department--a Class C misdemeanor may include a simple assualt, shoplifting, disorderly conduct, minor-in-possession, or other minor violations of the law) (TJPC, 1989d, p. 4). The other 63,687 juveniles who were arrested in 1988 were referred to juvenile probation departments. Another 7,034 referrals were made by people and agencies other than the police department. Figure 5.1 shows the intake, detention, and disposition of juveniles in 1988. Table 5.4 shows the referrals for the entire state in 1988 and divides the juveniles into numerous categories. The following discussion of this data will focus upon "referrals" as opposed to "individuals" because the TJPC tracks the probation departments' performance in terms of referrals processed through the system rather than individuals served.

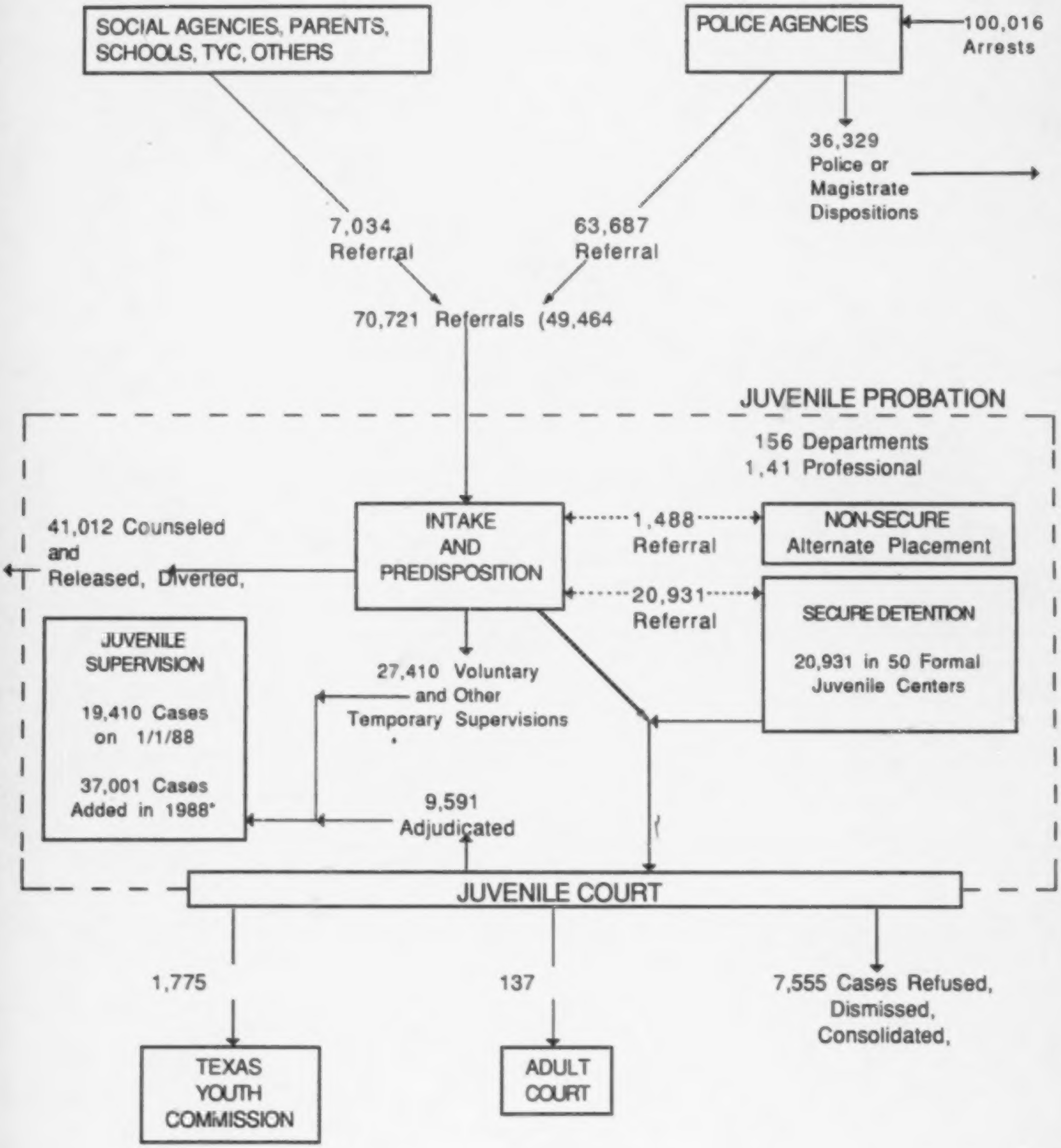
Referrals for 1988 were down by approximately 17,000 as a result of a change in the law which removes most Class C misdemeanors from juvenile courts. Total referrals for the past three years have been 70,721 in 1988, 86,016 in 1987, and 90,741 in 1986 (TJPC, 1988a, p. 10). For the past few years, the percentage of repeat juvenile offenders has been constant at 45 percent of total referrals (TJPC, 1989d, p. 11). In 1988, the 70,721 referrals to the probation departments included only 49,464 actual persons because some youth were brought in more than once.

Dropouts make up approximately 13 percent of juveniles referred. Of the 70,721 referrals in 1988, 1,749 showed symptoms of inhalant abuse, 11,127 were drug abusers, and 10,804 abused alcohol. Of these referrals, 1,790 had been sexually abused, 1,946 experienced physical abuse, and 11,244 were emotionally abused; these figures include double counts because some juveniles may be inhalant, drug, and alcohol abusers, for example (TJPC, 1989d, p. 11).

The categories of offenses for which youth are referred range from felony offenses and misdemeanors to status offenses and CINS (Conduct Indicating a Need for Supervision). Status offenses are offenses that are not criminal when committed by adults, such as running away and skipping school (truancy). CINS offenses include the status offenses plus DWI, inhalant abuse, and violation of certain laws punishable by fine.

Disposition. After a juvenile is brought into a probation department, an officer will determine whether the youth can go home prior to a court appearance, whether the youth must be detained until the court appearance, or whether the youth can go home without further action. As shown in Table 5.4, the majority of referrals in 1988 (41,012; typically 60 percent) were counseled and released, diverted, or dismissed, which means they did not have to appear in court. These juveniles are not put on probation, but they will have a permanent record which will be filed and will appear if they are referred again (in the same county). "Informal adjustment" is the term the TJPC uses for counseling. About 14 percent of all referrals are court-ordered to have informal adjustment. A juvenile that is "diverted" is sent to another agency such as MHMR or DHS. Typically, juveniles who are

Figure 5.1. Movement of Juveniles


SOCIAL AGENCIES, PARENTS, SCHOOLS, TYC, OTHERS
POLICE AGENCIES
100,016 Arrests
36,329 Police or Magistrate Dispositions
7,034 Referral
63,687 Referral
70,721 Referrals (49,464
JUVENILE PROBATION
156 Departments
1,41 Professional
41,012 Counseled and Released, Diverted,
INTAKE AND PREDISPOSITION
1,488 Referral
NON-SECURE Alternate Placement
20,931 Referral
SECURE DETENTION
20,931 in 50 Formal Juvenile Centers
JUVENILE SUPERVISION
19,410 Cases on 1/1/88
37,001 Cases Added in 1988*
27,410 Voluntary and Other Temporary Supervisions
9,591 Adjudicated
JUVENILE COURT
1,775
137
7,555 Cases Refused, Dismissed, Consolidated,
TEXAS YOUTH COMMISSION
ADULT COURT

Source: TJPC, June 1989b.

Table 5.4. Juvenile Probation Referral Aectivity Summary of 1988 Reported Activity
Statewide Totals

Total Number of Referrals = 70,721   Number of Children Referred = 49,469

	ALLEGED DELINQUENT BEHAVIOR															
	FELONY OFFENSES									CLASS A & B MISDEMEANORS					VIOLTN LAWFUL COURT ORDER	TOTAL DELIN
	HOM	SEX ASSALT	ROBB	AGG ASSALT	BURG	THEFT	MV THEFT	DRUG OFFS	OTHER	WEAPNS VIOLTN	ASSALT	THEFT	DRUG OFFS	OTHER		
NO PRIOR REFS	73	583	276	759	5,637	874	1,951	444	1,576	631	1,634	6,886	1,344	5,731	135	28,534
PRIOR REFS	67	257	410	692	5,431	893	2,030	437	1,030	434	1,305	2,965	876	3,886	3,032	23,745
NO PRIOR ADJ	108	758	530	1,196	9,164	1,467	3,114	713	2,227	880	2,536	9,044	1,920	8,256	853	42,766
PRIOR ADJUD	32	82	156	255	1,904	300	867	168	379	185	403	807	300	1,361	2,314	9,513
NO PRIOR COM	128	826	638	1,380	10,652	1,690	3,734	833	2,523	1,032	2,869	9,720	2,168	9,219	2,942	50,354
PRIOR COMM	12	14	48	71	416	77	247	48	83	33	7	131	52	398	225	1,925
POLICE AGENCY	139	803	678	1,414	10,783	1,712	3,833	856	2,472	1,017	2,757	9,562	2,090	9,019	1,789	48,924
SCHOOL	0	2	0	9	13	3	2	1	18	15	49	47	63	68	45	335
OTHER	1	35	8	28	272	52	146	24	116	33	133	242	67	530	1,333	3,020
COUNTY RESID	132	792	623	1,379	10,306	1,624	3,418	804	2,445	1,005	2,860	9,112	2,106	9,904	2,955	48,655
OUT OF CNTY	6	37	30	59	432	104	415	52	127	39	60	476	85	368	173	2,463
OUT OF STATE	1	7	3	8	86	23	129	15	24	14	13	71	14	61	35	504
OUT OF U.S.A.	1	4	30	5	244	16	19	10	10	7	6	192	15	94	4	657
IN SCHOOL	105	785	543	1,183	9,470	1,492	3,301	606	2,243	881	2,607	8,970	1,885	8,492	2,413	44,976
DROPPED OUT	28	40	116	194	1,291	222	532	207	268	124	211	678	188	793	576	5,468
SUSP/EXPELLED	7	15	27	74	307	53	148	68	95	60	11	203	147	332	178	1,835
10 YEARS OLD	1	18	6	19	264	21	14	0	72	5	55	238	10	245	8	976
11 YEARS OLD	1	32	12	18	400	36	41	0	96	7	103	508	23	379	24	1,680
12 YEARS OLD	3	64	24	68	770	67	98	8	180	35	189	857	63	695	104	3,225
13 YEARS OLD	12	133	64	129	1,359	171	347	46	299	80	405	1,519	192	1,261	260	6,277
14 YEARS OLD	16	187	123	248	2,059	299	772	97	453	212	600	1,990	422	1,862	610	9,950
15 YEARS OLD	39	187	171	435	2,777	519	1,266	250	648	282	726	2,287	669	2,314	971	13,541
16 YEARS OLD	61	190	271	516	3,253	626	1,399	448	804	434	823	2,379	824	2,742	948	15,718
17 YEARS OLD	7	29	15	18	186	28	44	32	54	10	38	73	17	119	242	912
WHITE MALE	31	350	107	329	4,243	542	1,250	215	1,108	319	806	2,785	634	3,595	943	17,257
WHITE FEMALE	4	19	19	61	307	101	273	107	208	31	267	1,002	186	781	296	3,662
BLACK MALE	41	254	279	434	2,061	530	872	308	467	194	651	1,955	179	1,662	703	10,509
BLACK FEMALE	1	7	26	103	71	58	49	24	69	49	187	746	25	268	139	1,822
HISPANIC MALE	54	198	206	461	3,886	431	1,315	188	655	431	747	2,196	1,048	2,841	907	15,584
HISP FEMALE	5	5	16	47	181	78	137	21	80	23	246	859	127	358	161	2,344
UN/ALIEN MALE	2	4	28	3	208	15	11	10	8	4	4	123	16	62	4	502
UN/ALIEN FEM	0	0	1	1	12	1	0	0	0	0	1	34	0	2	0	52
OTHER MALE	2	3	4	12	92	8	58	7	11	14	9	120	5	40	9	394
OTHER FEMALE	0	0	0	0	7	3	16	1	0	0	1	31	0	8	5	72
TOTAL REFS	140	840	686	1,451	11,068	1,767	3,981	881	2,606	1,065	2,939	9,851	2,220	9,617	3,167	52,279

TABLE 5.4 (CONTINUED)

	ALLEGED C.I.N.S. BEHAVIOR									GRAND TOTAL DELIN. AND CINS
	STATUS ONLY		OTHER THAN STATUS OFFENSES						TOTAL CINS	
	TRUANCY	RUNWAY	THEFT	DISORD CONDCT	INHALT	DWI/ DWID	LIQUOR LAWS	OTHER		
NO PRIOR REFS	1,778	5,051	1,046	824	98	239	632	908	10,576	39,110
PRIOR REFS	1,249	4,334	483	565	250	120	300	565	7,866	31,611
NO PRIOR ADJ	2,762	8,564	1,415	1,203	246	324	823	1,386	16,723	59,489
PRIOR ADJUD	265	821	114	186	102	35	109	87	1,719	11,232
NO PRIOR COM	2,991	9,267	1,511	1,344	323	347	908	1,458	18,149	68,503
PRIOR COMM	36	118	18	45	25	12	24	15	293	2,218
POLICE AGENCY	1,067	8,619	1,439	1,143	321	345	871	958	14,763	63,687
SCHOOL	1,600	55	37	96	11	1	12	75	1,887	2,222
OTHER	360	711	53	150	16	13	49	440	1,792	4,812
COUNTY RESID	2,996	7,706	1,388	1,334	339	315	819	1,408	16,305	64,960
OUT OF CNTY	30	1,106	116	52	4	38	99	50	1,495	3,958
OUT OF STATE	1	554	17	3	0	3	13	10	601	1,105
OUT OF U.S.A.	0	19	8	0	5	3	1	5	41	698
IN SCHOOL	2,785	8,234	1,411	1,246	259	285	824	1,317	16,361	61,337
DROPPED OUT	144	882	87	74	72	70	88	109	1,526	6,994
SUSP/EXPELLED	98	269	31	69	17	4	20	47	555	2,390
10 YEARS OLD	35	84	66	33	5	0	1	60	284	1,260
11 YEARS OLD	72	141	105	50	6	1	6	59	440	2,120
12 YEARS OLD	198	483	165	90	22	1	16	119	1,094	4,319
13 YEARS OLD	449	1,373	241	165	60	2	39	199	2,528	8,805
14 YEARS OLD	725	2,318	289	300	98	14	110	332	4,186	14,136
15 YEARS OLD	964	2,721	302	366	80	59	259	338	5,089	18,630
16 YEARS OLD	531	2,178	345	358	76	266	487	351	4,592	20,310
17 YEARS OLD	53	87	16	27	1	16	14	15	229	1,141
WHITE MALE	871	2,242	518	504	31	179	423	541	5,309	22,566
WHITE FEMALE	554	3,511	206	117	8	25	163	277	4,861	8,523
BLACK MALE	317	570	288	277	2	3	51	123	1,631	12,221
BLACK FEMALE	175	753	103	77	1	1	3	69	1,182	3,004
HISPANIC MALE	711	832	310	314	252	141	241	325	3,126	18,710
HISP FEMALE	383	1,390	86	95	53	10	48	117	2,182	4,526
UN/ALIEN MALE	0	9	7	0	1	0	2	17	36	538
UN/ALIEN FEM	0	1	0	0	0	0	0	0	1	53
OTHER MALE	10	30	10	3	0	0	1	3	57	451
OTHER FEMALE	6	47	1	2	0	0	0	1	57	129
TOTAL REFS	3,027	9,385	1,529	1,389	348	359	932	1,473	18,442	70,721

Source: TJPC, June 1989b. Tables 1 & 3.

dismissed are those who have committed a minor offense or are first offenders. Among those who are diverted are the juveniles placed in some type of residential facility.Table 5.5 shows the residential placements of juveniles in 1988.

More youth are being placed in residential facilities as a way to divert them from TYC. Although residential treatment is the most expensive form of placement, it is still less expensive than committing a juvenile to TYC by an average of $36 per child per day.

Another 27,410 juvenile offenders (from Table 5.4) were labeled "voluntary and other temporary supervisions" in 1988. The majority of these youth were transferred from one juvenile probation department to another. Others were held over from 1987 waiting for their court date. For this reason, the numbers in Table 5.4 do not add up to the 70,721 referrals. Some juveniles referred in 1988 did not have a disposition until 1989, just as some referred in 1987 were dispositioned in 1988.

The 7,555 cases that were refused, dismissed, consolidated, or otherwise disposed of were typically consolidated. This means that if a juvenile committed several offenses, the lesser offense(s) may not be taken to court in an effort to save time and money. Some cases are refused because the judge does not have an appropriate solution to the offense. Typically 11.5 percent of the cases are dismissed by the court.

The remaining dispositions include the adjudicated probationers (12 percent), the juveniles committed to TYC (2.5 percent), and the juveniles certified as adults. Adjudicated juveniles are those who are found guilty of their offense and then put on probation. The others who are committed and certified are no longer in the juvenile probation jurisdiction.

Of those on court-ordered probation in 1988 (9,064), approximately 11 percent (1,026) failed the probation requirements and ended up in TYC or were certified for adult criminal court (TJPC, 1989d, p. 19).

Detention. Detention is not considered a disposition of a juvenile because detention is simply a temporary place for offenders to stay while the disposition is being decided. There are currently 50 detention centers in Texas, as shown in Figure 5.2. This number represents a great increase from the 31 detention centers that were operating in 1981. Some of these are multicounty facilities which provide regional services on a contractual basis (TJPC, 1988b, p. 9). The detention centers are secured and provide a structured agenda for the youth who stay there. Youth may stay from one day to six months, depending on the case. As Table 5.4 shows, 20,931 youth spent at least one night in a secure detention center in 1988. Problems with detention have recently been studied by the TJPC and are discussed later in this chapter.

Programs and Services. Juvenile probation departments have become aware of the need for increased services to help youth in trouble overcome their problems. Even so, there is still a gap in services, especially in the smaller counties. Innovative programs have been developed within some county juvenile probation departments, while others contract such services. Programs which are typically available include drug/alcohol abuse treatment, sexual abuse/sexual offender counseling, services for the mentally retarded or emotionally disturbed, services for dependent and neglected children, school truancy programs, financial restitution plans, and community service. Table 5.6 shows the number of probation departments which provide specific programs and services and the number of juveniles served by these programs and services in 1988. Although not shown in the table, sexual abuse/sexual offender counseling is also provided in a few counties.

As can be seen in the table, only 482 youth in Texas who were referred to probation departments received services for mental retardation or emotional disturbance. This is less

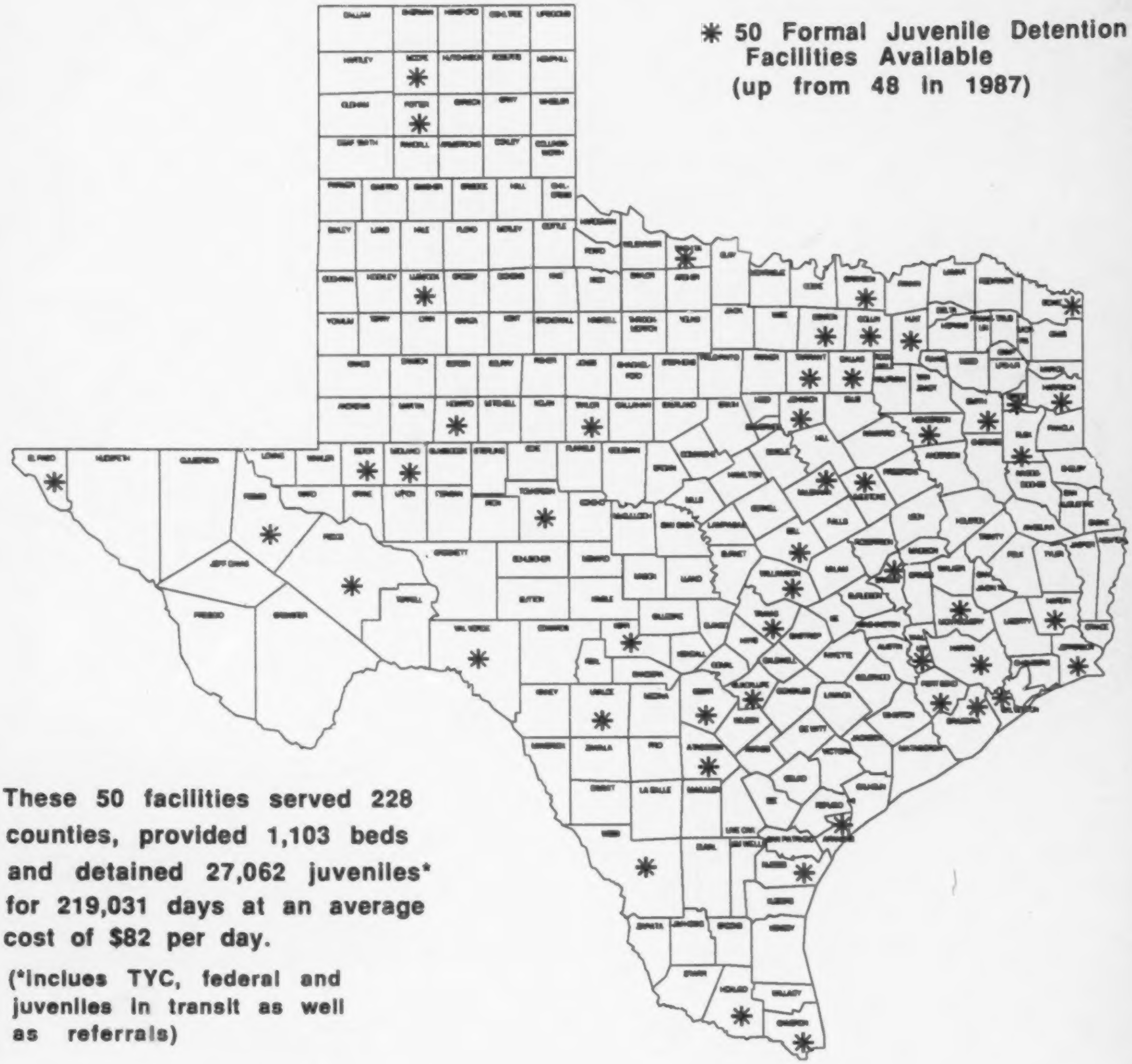
Table 5.5. Juvenile Probation Placements 1988

Type of Facility	Number of Placements	Percentage of Total	Average Days in Placement	Average Per Day Cost
No Cost Private*	504	12.0	80	N/A
No Cost State*	334	7.9	86	N/A
County Operated	896	21.3	107	$50
Foster Homes	491	11.7	52	$15
Residential Facility	1,978	47.1	77	$43
TOTAL	4,203	100.0	81	$34

Source: TJPC, 1989d, p. 8.

*Services provided by state facility, charities, private insurance, etc. and are not charged to the TJPC.

Figure 5.2. Juvenile Detention Centers 1988



✳ 50 Formal Juvenile Detention Facilities Available (up from 48 in 1987)

These 50 facilities served 228 counties, provided 1,103 beds and detained 27,062 juveniles* for 219,031 days at an average cost of $82 per day.

(*inclues TYC, federal and juveniles in transit as well as referrals)

Source: TJPC, 1989a.

Table 5.6. Probation Services

Services Provided	Depts. Reporting Services Available Within the Dept.	Depts. Reporting Services Available Outside the Dept.	Juveniles Served*
Substance Abuse Treatment Programs	64	134	13,138
MR/ED Children Services	18	114	482
Title II Services (dependent & neglected)	12	93	1,225
Child Support Services	18	73	46,083
School Truancy Programs	104	67	6,485
Financial Restitution	124	20	3,547
Community Services Restitution Programs	73	26	2,584

Source: TJPC, 1989d, p. 9.

*Not all departments were able to give a precise number of juveniles served.

than 1 percent of the number of children referred to probation departments that are getting treatment for either mental retardation or emotional disturbance. Obviously, an enormous need is not being met in either identifying youth with mental or emotional problems or helping those youth who are identified. Psychological treatment for these youth is the least available service in juvenile probation departments, probably due to the high cost. Residential treatment centers are the typical placement choice for youth with emotional problems, and sometimes for youth with mental retardation (though few residential treatment centers will accept metally retarded youth). Of all the states, Texas ranks very low in the amount of money spent on residential treatment facility placements. In fact, other states are using Texas facilities more than Texas youths are (TJPC, 1988b, p. 10).

The number of youths who received some type of substance abuse treatment in 1988 was 13,138. This is only 25 percent of the number of youths referred during that year. Administrators at the TJPC estimate that at least 80 percent of the youth referred have substance abuse problems (Robinson, Interview, April 17, 1990). This means 55 percent are left to overcome substance abuse problems on their own, which is unrealistic. And even those who do receive treatment do not always complete that treatment successfully. Treatment needs to be available to 100 percent of those youth needing it.

Other Initiatives. Juvenile probation departments are also attempting to work more closely with school districts. The Texas Education Code requires that each school district appoint a school liaison with the juvenile probation department, and so far 693 (out of almost 1,100) school districts have complied (TJPC, 1988b, p. 9). Departments are also trying to work closely with families to get them involved in the youth's rehabilitation.

After the Sunset Advisory Commission Report in 1986, the 70th Legislature required that juvenile probation departments begin assessing court and probation fees against adjudicated juveniles. A sexual abuse program has also been initiated in several counties.

One written objective of the TJPC is to have the individual probation departments observe and study the children in order to detect emotional or mental problems. There are major differences in the outcome of detection by county. Dallas, for example, has several psychologists on staff who assess any children referred by an intake officer when the child seems to have emotional problems. These psychologists are familiar with over 60 residential treatment centers to which the juveniles with emotional problems are usually sent.

THE COURT SYSTEM

The court is an integral part of the juvenile justice system since the judges make decisions which will affect the juvenile delinquents' lives. The TJPC believes that Texas has an excellent juvenile law (Title 3 of the Texas Family Code). It is progressive and functional, and equal to or better than other state juvenile laws (TJPC, 1988b, p. 1). Texas uses juvenile court referees as well as county (district court) judges to serve as juvenile judges. These judges are required to have periodic specialized training provided by the TJPC as well as the Texas Center for the Judiciary, the Judicial Section of the State Bar of Texas, and the National College of Juvenile Justice (TJPC, 1988b, p. 2). Typically, the nation's juvenile court judiciary is not held in high regard, but Texas, with few exceptions, has competent and experienced judges who have a "sympathetic understanding of the problems of child welfare" (TJPC, 1988b, p. 2).

A philosophy which Travis County Judge Paul Davis and the Travis County Juvenile Court have adopted is the "balanced approach" to juvenile justice. Other counties and other states have adopted this approach, which takes three main factors into account--

youth accountability, competency development, and community protection (Maloney, Romig, and Armstrong, 1988).

Youth accountability means not only should the juvenile offender be responsible for the delinquent actions but also made aware of the loss, damage, or injury perpetrated on the victim. Typically, a youth will be required to pay restitution and/or perform community services as a way to enforce accountability.

The second aspect of the balanced approach, competency development, is based on research which shows that the majority of youth adjudicated for major crimes against persons and property have experienced high levels of social deprivation and have not completed the maturational development process. Competency development is a practice which focuses upon the need to transmit social competence, vocational training, employability, and other life skills to adjudicated youth. It is an extension of traditional counseling and psychotherapy.

The third part of the balanced approach is community protection and public safety, which are major concerns when trying to divert juvenile offenders from the secure correctional facilities to probation. There are many approaches to protecting the community, including the following: house arrest and detention, mandatory substance abuse treatment, electronic monitoring, reparative sanctioning, and intensive probation supervision.

These three aspects of the balanced approach can work only if there is individualized assessment and treatment. Currently, juveniles are placed in the legal categories of delinquent, status offender, CINS, and abuse and neglect; they are also placed in risk management categories of high, medium, and low risk to self and/or the community. Diagnostic assessments are used to determine an appropriate treatment. Sometimes assessment will also include a look at family, friends, school, personal attitudes, and skill deficits which may have contributed to the offense behavior. Finally, this is called a "balanced approach" because there is a need for the community, victim, and youth to receive balanced attention and gain tangible outcomes from an interaction with juvenile probation.

LEGISLATIVE CONTEXT FOR SED CHILDREN'S SERVICES WITHIN THE TJPC

Currently, there is very little legislation regarding emotionally disturbed children in the juvenile justice system, and there is no legislation for seriously emotionally disturbed children. The Texas Family Code, Title III, allows courts to temporarily hospitalize children who are allegedly mentally ill in order to observe and treat the child.

Recently, a provision was added to the Texas Family Code that made it possible for a juvenile determined to be mentally ill to be committed to the Texas Department of Mental Health/Mental Retardation for placement in an appropriate facility for up to 90 days. Placing a mentally ill youth who is also a juvenile offender can be very difficult if not impossible. Even if an appropriate facility is found, the facility may have a waiting list. So the juvenile offender who is also mentally ill may be sent back to the community with minimal service in many cases.

Challenge Grants are the only source of funding which consider the special needs of SED children and adolescents. General TJPC funds may be used for this population but are not specifically designated for this purpose.

CURRENT ISSUES OF CONCERN

Issues Determined by Senate Select Committee on Juvenile Justice

The Senate Select Committee on Juvenile Justice developed a survey in 1988 which was sent to juvenile judges, chief juvenile probation officers, child protective service workers, TYC workers, juvenile law enforcement officers, child advocacy groups, and school superintendents to determine critical issues and needs in the juvenile justice system. Out of 900 surveys, 389, or 43 percent, were returned. The survey was divided into four sections: prevention issues, service delivery, special needs, and coordination. Respondents were asked to rate problems "as to the degree that each hinders the children and youth services/juvenile justice systems in Texas in effectively helping or rehabilitating youth." The average responses to many issues showed that there is a "significant problem" to a "critical problem" with these systems achieving their goals.

Prevention Issues. The most significant problems associated with preventative services as determined by the survey are the lack of treatment services for youth under the age of ten who are at high risk of entering the juvenile justice system as well as the inadequate number of effective school programs to address parenting training and dropout prevention. Another problem with prevention is the lack of a coordinated referral process among law enforcement officials, teachers, school counselors, and others in the early identification of youth under the age of ten at high risk of entering the juvenile justice system. In addition, there is a need for more effective school programs addressing substance abuse, sex education, teen pregnancy, truancy, and runaways. Of particular importance is the need to develop early intervention programs which involve youth and their families. Finally, there is an inadequate number of effective youth and family programs aimed at preventing child abuse, neglect, and exploitation in order to minimize the number of children entering the juvenile justice system (Texas Legislature, Senate Select Committee on the Juvenile Justice System, 1989, Appendix).

The Senate Select Committee on Juvenile Justice also received testimony and reports which outlined one typical pattern of childbirth and child development that may be associated with learning problems, mental or emotional problems, and juvenile delinquency (and later adult crime) (Texas Legislature, Senate Select Committee on the Juvenile Justice System, 1989, p. 2). The committee believes some of the causes to be low birth weight, a mother who did not have family planning or adequate prenatal care, a lack of either Early Childhood Intervention services or a Headstart program, and an overall mentality for failure. Although this analysis touches on some of the problems associated with emotional disturbance, it is not a complete picture of the wide array of problems that may set off emotional problems in children. A low birth weight does not necessarily mean a child will have problems later on. Children must be analyzed individually to determine which programs will be appropriate.

Certainly, Early Childhood Intervention and Headstart programs help disadvantaged children, but there are many youth who are past the age targeted by these programs. Many youth who are frustrated by family problems, school failure, and poor peer relationships turn to street crime for survival and end up cycling through the courts, juvenile probation, TYC, adult probation, the Texas Department of Corrections, and the parole system. These youth need programs to help work out family problems and build self-esteem, such as the Communities-in-Schools program. Moreover, emotionally disturbed girls who become pregnant at an early age and end up in and out of the welfare system need programs focused on their needs (Texas Legislature, Senate Select Committee on the Juvenile Justice System, 1989, p. 2).

The TJPC does not currently fund prevention services or programs, but the Senate Select Committee recommends such funding.

Service Delivery. One of the main problems associated with service delivery is the fact that after a juvenile offender receives treatment outside the home, there is not enough involvement when the child is returned back home. This problem is especially true of the youth who are sent to TYC. Further, the Senate Select Committee's study revealed that the length of stay in TYC is too short for violent and serious offenders. Similarly, while the child is in TYC (or juvenile probation or child protective services), families are not taught coping skills such as problem-solving, decision-making, effective interpersonal communication, and disciplining methods.

A second major problem with service delivery is that there are too few available community-based programs and services. The community-based programs serve as alternatives to removing children from their homes for both juvenile probation and child protective services. Sometimes community-based programs may also meet the needs of children who would otherwise be committed to TYC. There are also too few affordable contract care residential placements that provide appropriate services in the least restrictive setting. For those youth who remain in their homes, there is a great need for substance abuse treatment programs; moreover, there is a critical need for specialized substance abuse services for youth in residential and state facilities.

A third problem area is that there are no studies (particularly longitudinal) which determine the effectiveness of programs that are intended to rehabilitate youth and thereby reduce recidivism. The recidivism rate for juvenile offenders is still very high at 45 percent (TJPC, 1989d, p. 11) and is related to the lack of preparation for return (discharge planning) to the home and the scarcity of aftercare services. Understandably, if a juvenile offender is returned to a dysfunctional home with no help for the child or family, the youth will probably go back to old, harmful patterns of behavior.

A fourth problem area is educating juvenile offenders. There is too little use of creative alternative educational programs that differ from the traditional public school model in which most juvenile offenders have been unsuccessful. Vocational education, job training, job advancement, and career decision-making skills training should be available for all youth in the juvenile justice system so that when they return home they will have basic survival skills.

Special Needs. There seems to be a very significant problem of too few residential and nonresidential programs and services for youth who have severe conduct disorders, emotionally disturbed/mentally ill youth, emotionally disturbed/mentally ill youth who are violent, sex offenders, violent youth, illiterate youth, gang-involved youth, mentally retarded youth, and youth with learning disabilities. There is a critical shortage of residential substance abuse programs for youth who do not voluntarily agree to treatment.

Coordination. The greatest problem with coordination exists between state and local service programs. In addition, there is a lack of communication between families with children involved in the juvenile justice system and representatives of law enforcement agencies, state agencies, contract care facilities, and the court system.

Issues Determined by the Runaway Task Force

A Runaway Task Force Committee was set up in Travis County in September 1988 to determine the scope of the local runaway problem and to attend a national conference on this issue in Washington, D.C. The conference was meant to act as a motivator for the local community agencies and the juvenile family courts to work together to find solutions for missing, runaway, and exploited children. The task force members include district judges and court referees as well as representatives from the District Attorney's Office, Travis County Juvenile Court, Texas Department of Mental Health/Mental Retardation, Texas Department of Human Services, Austin Independent School District, Middle Earth

Unlimited, and the TRIAD program. In 1989, the task force released a report which spelled out the problem of runaway children in Travis County (Runaway Task Force Committee, 1989). The problem of children running away from abusive and dysfunctional families has increased dramatically in the past decade. Some of these children are brought into emergency shelters and are eventually returned back home, while others turn to street crime such as prostitution and drugs in order to survive.

Since 1974, there have been initiatives to deinstitutionalize status offenders such as runaways and truants. Therefore, a majority of these children are no longer helped by the juvenile justice system until they are caught committing a serious crime (Runaway Task Force Committee, 1989, p. 3). Since these runaways are no longer sheltered by juvenile justice facilities, the burden is transferred to Child Protective Services and the public mental health system, which have experienced shortfalls in funding. Thus, services are increasingly unavailable for street children, runaways, and families in need of specialized services in order to care for children who may be at risk of becoming delinquent.

Currently, there are approximately 22 runaway centers in Texas funded by federal grants. An additional 20 runaway service providers are funded by state grants from the Services to Truants and Runaways Division of the Texas Department of Human Services (TDHS). The services for which TDHS contracts include family crisis intervention, emergency short-term residential care, family counseling, parenting skills training, and youth coping skills training. The state requires cooperative working agreements between the local TDHS and TJPC offices.

As mentioned earlier, runaways cannot by federal law be housed in detention centers for more than 24 hours (TJPC, 1988b, p. 8), and so the court must often return the child to a home where maltreatment is suspected unless there is available shelter space. In 1988, however, space was not available to at least 500 runaways needing it (Runaway Task Force Committee, 1989, p. 3). Counseling is available to both the child and the family through a community agency or through the Delinquency Prevention Division of the Juvenile Court. TDHS can also provide services if the runaway has allegedly been abused or neglected. Further, Child Protective Services provides services to runaways who have been physically or sexually abused or abandoned. Even so, services to runaways are ill defined and poorly administered (TJPC, 1988b, p. 8).

According to a study conducted by the Runaway Task Force Committee in Austin in 1989, many services are available, but "lack of coordination among agencies lessens the effectiveness of the services" (Runaway Task Force Committee, 1989, p. 3). Furthermore, there are still gaps that exist in services, and adequate funding for programs is a desperate need. For example, local MHMR agencies can place children with mental, emotional, or substance abuse problems in state facilities, but often these facilities are full and waiting lists are long.

A suggested solution for part of this problem would be case management in which the case manager would maintain contact with a street child and would be able to respond immediately to the child's need. The case manager would be familiar with all agencies and services available, solving the problem of coordination. Another solution would be to establish more programs like TRIAD in Austin, which provides residential child care to several children who have no sponsoring agency to pay their child care fees. This type of program is beneficial because it keeps the child from having to be labeled delinquent before receiving agency funding for placement. The Runaway Task Force Committee summed up the problem as follows:

> Runaway, missing and exploited children have a myriad of problems that affect this community's public child systems--mental health, school, juvenile justice, and protective services, as well as many community services agencies.

> All of these systems and several agencies can be providing services to the same child at the same time. Usually there is little coordination of these services, with each agency applying one band-aid after another to the huge and complicated problems presented by these children and their families until finally the child or the family hit the "big time" and a crime or serious abuse or neglect occurs. (Runaway Task Force Committee, 1989, p. 3)

Specific needs identified by the task force include a detoxification program, more inpatient substance abuse treatment for indigent children, case management or continuum of care, parent participation in treatment, more shelter care for status offenders, more agency collaboration, a better foster-care program, and, finally, community action plans for dealing with runaway and street children in Texas.

The Overcrowding/Overuse of Detention Centers

The overcrowding of the Dallas County Juvenile Detention Center led to a study conducted by the TJPC in March and April of 1989. The authors of the study expressed their feelings toward the situation in Dallas this way:

> Detention does not deserve to be a major part in the juvenile justice process. It should be brief, terribly selective and modest in its aims. If the rest of the system behaves, it should almost disappear . . . detention should not be, as it is now, the hidden closet for the skeletons of the rest of the system. (TJPC, 1989a, p. 5)

Since 1985, the detention center in Dallas has been used above its capacity of 101. Around the time of the study, the center held 197.

A juvenile should not be put in detention prior to the court hearing unless the juvenile is likely to leave the jurisdiction, living without suitable supervision, likely to commit another crime or cause harm to self or others, or is a repeat offender. Otherwise, detention centers will become overcrowded and understaffed. According to the Dallas study, "detention can generate substantial psychological and emotional trauma for the allegedly delinquent youth" (TJPC, 1989a, p. 8). The study further argues that the disruptive effects of detention in a child's life "runs counter to any rehabilitative efforts" and that the detention center's environment "may serve to promote rather than discourage future delinquency behavior" (TJPC, 1989a, p. 10).

For an emotionally disturbed child, detention would most likely have a very traumatic effect. Therefore, it is very important that some observations be made of all referrals during the intake function and before a child is put in detention. Counseling, therapy, and treatment are not offered in detention centers, making them a particularly inappropriate place for SED youth. Nor are there programs for drug, alcohol, or inhalant abusers in the detention centers. There seems to be an awareness that these problems (emotional and addictive) exist, but too little is being done to provide therapeutic services to juveniles referred to the probation departments.

Other Issues

Parent Accountability. There is a great need to get families more involved in the treatment of their children. The families should feel partly responsible or accountable for the children's actions. Therefore, mandatory community service and/or fines should be imposed on families who are in judicial contempt or who violate an order of the court (Texas Sunset Advisory Committee, 1986, p. 43).

Agency Guidelines. Currently, many agencies can legally deny or defer responsibility for serving a child and family, and their limited resources mean that they often do.

The Senate Select Committee on Juvenile Justice suggests that Title III of the Texas Family Code be changed. The committee recommends that the TJPC be given the new name of the Juvenile Services and Supervision Commission along with a broader mandate of aiding the development (with adequate funding) of community services for dysfunctional families. The recommended services include early intervention, in-home family services, intensive family intervention (such as the Homebuilders program), and foster care. More intensive supervision (such as electronic monitoring) is also recommended as an effort to keep even more children out of TYC.

Emotionally Disturbed Children

Although emotionally disturbed youth were not pointed out specifically as lacking the necessary services or programs, they fall into each of the above-mentioned problem areas. In fact, as individuals with serious emotional disturbances or mental illness, they pose an even greater problem to the juvenile justice system. Treatment programs will have to be more intensive, and initial assessment procedures will have to be more in-depth to determine how best to help SED/mentally ill youth. This extra attention will naturally require more resources in an already financially strapped system.

PROGRAMS FOR YOUTH IN THE JUVENILE JUSTICE SYSTEM WITH MULTIPLE NEEDS

Proyecto Esperanza (Project Hope), Houston

In 1984, the Office of Juvenile Justice and Delinquency Prevention (OJJDP) began funding a national program aimed at the Hispanic population's delinquent youth. The program helps reduce juvenile delinquency by treating some of the underlying family problems such as child abuse and neglect. Concerned about the high incarceration rate among Hispanic youth and aware of the strong links between child abuse, running away from home, and delinquent behavior, the OJJDP awarded $900,000 to the National Coalition of Hispanic Health and Human Services Organizations (known as COSSMHO). Proyecto Esperanza was implemented in eight communities: Albuquerque, New Mexico; Elizabeth, New Jersey; Guadalupe, Arizona; Hartford, Connecticut; Houston, Texas; Las Vegas, Nevada; Sacramento, California; and Salt Lake City, Utah. COSSMHO was aided in setting up the programs by local community-based agencies and professionals. These groups and individuals offered expertise in the areas of health, mental health, substance abuse, human services, and opportunities for youth. Some of the various programs include teen pregnancy prevention, delinquency prevention, youth development, and mental health research and training. Most sites have combined direct services, such as counseling and shelter placement, with public education programs that target the Hispanic community.

Houston set up a Host Home program which places homeless or runaway youth in private homes. The host families were specially trained on the development stages of children and the special needs of adolescents who have been sexually abused. Each of the first eight sites set up programs to fit the special needs of that community (U.S. Department of Justice, 1988a).

Paint Creek Youth Center, Cincinnati

Paint Creek Youth Center is a full-service correctional center for youth run by New Life Youth Services, Inc. (New Life). New Life is a large nonprofit, private, community-based youth service organization. This agency provides community-based residential, employment, and vocational services to delinquent and high-risk youth in Cincinnati. In 1984, New Life received $982,000 from OJJDP to implement a private-sector corrections program.

The treatment program at Paint Creek is rather unique. It is headed by a clinical psychologist with over 20 years of experience with juvenile delinquents. The central treatment approach is based on a positive peer community. Many of the youth at Paint Creek have histories of problematic interpersonal relationships and low self-esteem. The youth center also stresses personal responsibility, empathy for victims, and peer support groups. The aim is to make the youth open, honest, and responsible members of society.

The program also helps the youth adjust to being released back into the community with educational and employment training. Furthermore, the parents are included in the treatment, especially prior to the juveniles' release. So far, the youth center seems to have been highly successful. After release, 88 percent of the "graduates" of the program were either going to school full time or were working full time (U.S. Department of Justice, 1988b).

Abraxas, Pennsylvania

The Abraxas Foundation operates treatment programs for juvenile offenders who have histories of drug and alcohol abuse, suicide attempts, and unacceptable behavior toward people and property. These youth are typically from broken homes. The program treats youth by putting them in a rustic, isolated setting which induces the youth to work together. There is also a school located on the grounds, and each youth has a counselor who gives individualized attention. Each youth has a treatment plan which is evaluated monthly by the counselors to ensure progress is being made. Youths stay in this phase for six to nine months during which they attend individual and group encounter sessions including special groups concerning the needs of women, family relations, or alcoholism.

The next phase of the program moves the youth to a group home of 15 to 20 residents and several counselors who help the youth make the transition back into the environment in which they originally had problems. In this phase, the youth's family and probation officer become more involved. Finally, after about six months in this setting, the youth is returned home or is helped in setting up a home in the community. Counseling sessions are continued until the youth feels secure and independent.

Some additional programs provided by Abraxas include ASSIST, a drug and alcohol treatment program; Supervised Independent Living (SIL), for program graduates who cannot return to their families; Abraxas Family Organization, which helps the family support the treatment of the youth; and graduation ceremonies for the youth.

The cost of Abraxas treatment is charged to the referring court but is greatly reduced by grants from the Office of Drug and Alcohol Programs, the U.S. Department of Education, and other public organizations. If the courts are not satisfied with the results of the program, they can simply stop referring youth, but so far the program has shown positive results (U.S. Department of Justice, 1984, p. 15).

Summary of Model Programs

These programs all show some collaboration among the youth, family, community, education system, and courts. Programs like these exist in Texas, but far too many youth are turned away because they do not meet the qualifications. Texas needs a system which can serve all youths in need, no matter what problems they have. Placing youth in secure confinement without treatment will not help the child return to society and lead a productive life. Texas needs a plan to pool its resources and use them more effectively for a productive generation of youth.

CONCLUSION

This chapter has shown that programs and services for SED youth in the juvenile justice system are lacking in several significant areas.

Prevention. SED youth are sometimes identified through the school system. As soon as early warning signs show up, early intervention programs should be available. The juvenile justice system should work with the school system to implement programs to help these youth before they get involved in criminal activities. The TJPC should coordinate with TEA and TDHS to determine appropriate programs to implement in elementary and secondary schools as a way to reach children who are at risk. The Communities-in-Schools program is a good example of determining at-risk youth and pulling them aside on a regular basis to help them deal with problems at home and in school. The TJPC and TDHS should join in this effort so that the entire financial burden is not on the schools and so that more youth can be helped.

Assessment. There needs to be a suitable assessment process which recognizes the at-risk youth as well as the youth already showing the symptoms of severe emotional disturbance. The TJPC should develop an assessment system and use it on all youth who are detained or adjudicated. Further, the TJPC should decide whether or not it will handle SED youth.

Treatment/Therapy for SED Youth in Detention, in Foster homes, or on Probation. Typically when juveniles are determined to have emotional or mental problems, they are kept out of detention but not always. Detention may add to a juvenile's emotional problems (TJPC, 1989a, p. 5), but sometimes there is no alternative to detention if the home is dysfunctional and there is no foster care available. A policy should be established regarding whether SED youth can or cannot be kept in detention centers. Detention centers do not seem to be an appropriate place for SED youth because they do not provide any type of treatment and may even cause more trauma for the youth. Further, youth on probation (at home) do not get the type of treatment necessary to help an SED problem. Therefore, if adjudicated juveniles are kept under the jurisdiction of the TJPC, then the TJPC should work with TDHS or TDMHMR to get counseling along with supervision for the juvenile probationers. There also seems to be a demand for foster homes that provide not only shelter but also counseling and nurturing for SED youth.

Drug/Alcohol Rehabilitation Services for SED Youth. Youth who are depressed or socially unadapted often resort to drugs or alcohol. More drug/alcohol rehabilitation services need to be provided for these youth. The TJPC should coordinate with TACADA to provide these additional programs to a younger population that TACADA normally does not consider a priority population.

Case Management. Case management can be used to involve all relevant organizations, agencies, and individuals in developing a community treatment plan that turns an array of diverse services into a comprehensive system of intervention.

Reintegration into the Community. Treatment programs are typically successful in changing youths' behaviors while they are in the highly structured environment of the program. But once returned to the original environment that caused the problems, the youths will resort to the habitual behavior. Therefore, aftercare is essential for the ultimate success of residential and institutional programs.

Coordination with TDMHMR, TDHS, and the School Systems. With the multiple problems of most SED youth, multiple agencies must be involved in the solution. Not only will interagency coordination maximize the effectiveness of treatment, it will ensure that youths do not fall through the cracks. The resources available for treatment will also be increased and better allocated by coordinating the fragmented components.

References

Legislative Budget Board. 1989. Legislative Budget Estimates for the 1990-1991 Biennium. Austin, Tex.

Logan, Bob. 1990. Director of Statistics and Reports, Texas Juvenile Probation Commission, Austin, Tex. Interview, January 11.

Maloney, Dennis, Dennis Romig, and Troy Armstrong. 1988. "Juvenile Probation: The Balanced Approach." Juvenile and Family Court Journal, vol. 39, no. 3.

Robinson, Steven. 1990. Cheif Probation Officer, Texas Juvenile Probation Commission. Austin, Texas. Interview by Vicki Vondracek (April 17).

Rudeseal, Keith. 1989. Program Specialist, Texas Juvenile Probation Commission, Austin, Tex. Interview, October 6.

Runaway Task Force Committee. 1989. "Missing, Runaway and Exploited Children in Austin: A Report to the Community."

Tex. S.B. 222. 1989. 71st Leg., Reg. Sess.

Texas Juvenile Probation Commission (TJPC). 1989a. A Study of the Overcrowding in the Dallas County Juvenile Detention Center, Austin, Tex.

___________. 1989b. Annual Report for 1988. Austin, Tex.

___________. 1989c. Disposition of Juvenile Offenders, Austin, Tex.

___________. 1989d. Statistical Report for the Calendar Year 1988. Austin, Tex.

___________. 1988a. Annual Report for 1987. Austin, Tex.

___________. 1988b. Status Report on the Juvenile Justice System, March 1988, Austin, Tex.

___________. n.d. "Guidelines for Challenge Grant Agreements." Austin, Tex.

Texas Legislature, Senate Select Committee on the Juvenile Justice System. 1989. Blueprint for Prevention: The Future of Juvenile Justice in Texas. Austin, Tex.

Texas Sunset Advisory Committee. 1986. Texas Juvenile Probation Commission. Austin, Tex.

U.S. Department of Justice, Office of Juvenile Justice and Delinquency Prevention. 1988a. Juvenile Justice Bulletin. Washington, D.C.

___________. 1988b. Juvenile Justice Bulletin: OJJDP Update on Programs. Washington, D.C.

___________. 1984. Drug Abuse, Mental Health, and Delinquency. Washington, D.C.

Chapter 6. Texas Youth Commission

HISTORY

The age of adult criminal responsibility in Texas was seven in 1836 and was raised to nine in 1856. In 1859, the Texas Legislature authorized separate correctional facilities for child and adult offenders, although no funds were appropriated. Eighteen years later, funds for a separate youth facility, the Gatesville State School, were appropriated. In 1889, Gatesville opened to serve 25 boys between 12 and 15 year of age. In that same year, the Corsicana State Home opened as an orphanage. In 1916, a correctional facility for girls was opened in Gainesville. In 1918, the age of responsibility was raised to 17 (TYC, 1989a).

In 1949, the Texas Youth Development Council was founded to assist communities in developing child services and to administer the state's correctional facilities for youth. The name was changed to the Texas Youth Council in 1957. Its mission was more directly centered on providing services for delinquent youth, and it added the function of providing parole services. By 1972, the council was administering five facilities for delinquent youth (Sunset Advisory Commission, 1987) .

In 1971, a federal civil rights class action lawsuit filed in Texas, Morales v. Thurman, had a significant impact on the delivery of juvenile justice not only in Texas but in many other states as well. Before then, the primary emphasis in caring for delinquent youth in all states had been institutionalization. Morales changed the emphasis to include community care as an alternative to institutionalization, and, in addition, it required that service be less restrictive. It also addressed such issues as adequacy and quality of staff, treatment and punishment standards, and complaint and redress procedures. At present, a primary goal is to include the private sector as suppliers of juvenile services (Cannedy, 1988).

In 1976, through the Community Assistance Program (CAP), the Texas Youth Council implemented a legislatively mandated (Senate Bill 277) probation program for juveniles. Its purpose was to increase the use of community alternatives and to decrease commitments to the council. The Texas Juvenile Probation Commission was created as a separate entity in 1981 and assumed the responsibilities of CAP (TYC, 1989a).

In 1983, the agency's name was changed to the Texas Youth Commission (TYC). It has as its mission

> . . . to administer the state's correctional facilities for delinquent children, to provide a program of constructive training aimed at rehabilitation and re-establishment in society of children adjudged delinquent by the courts of this state . . . and to provide active parole supervision of such delinquent children until officially discharged from custody . . . (Texas Youth Council, 1957, p. 1)

Of youth who violate the law, only 3 percent are served by TYC.

AGENCY OVERVIEW

Administrative Structure

TYC is governed by a six-member board (Appendix 6.1). The members are selected because of their interest in youth. They are appointed by the governor with the consent of the Senate to staggered six-year terms. The chairman of the board is selected by the board from its membership.

TYC's central office is located in Austin. The commission has six area offices and 12 district offices throughout the state.

The executive director of TYC is appointed by the board (Appendix 6.2). It is the responsibility of the executive director to oversee the daily operation and management of agency programs and to implement the policies and directives of the board.

The deputy executive director serves under the executive director and is charged with the responsibility of overseeing the Direct Care Services Division, which includes the Institutions Department, the Statewide Reception Center, and the Community Services Department. The Community Services Department is responsible for those services that care for youth in the community, including the halfway houses and the parole offices, for contracting for care outside of TYC-run facilities, and for handling both the interstate and intrastate movement of youth (escapees, parolees, etc.). TYC's community service programs are administered through five regional locations.

Two assistant executive directors also serve under the executive director. One is in charge of the Professional Services Division, and the other is in charge of the Support Services Division.

The Professional Services Division is made up of Legal Services, Youth Rights Administration, Manuals Policy Coordination, Volunteer Services, Education Services, Chaplaincy Services, and Health Care Services. This division works at two levels. It supports the executive office in legal matters, in public relations, and in agency publications and brochures. And it is responsible for the planning and implementation of the legal, physical, spiritual, psychological, and educational needs of the youth in the agency's care.

The Support Services Division is made up of Fiscal, Maintenance and Construction, Personnel and Staff Development, Management Information Systems, and Staff Services. These are the groups that provide administrative support in the day-to-day operation of TYC and its facilities.

Categories of Service

TYC has two classes of service: institutional (including the Corsicana Residential Treatment Center) and community-based, which includes contract care, halfway houses, and parole. A youth who is adjudicated to TYC will first be sent to the Statewide Reception Center in Brownwood or the Mobile Regional Juvenile Center in Edinburg, which serves only youth from South Texas. There the youth will be given an intake interview, a series of psychological and educational tests, and medical and dental examinations. He or she will be evaluated on the basis of intake tests, age, committing offense, criminal history, and aggressiveness. From this information a risk/needs assessment is completed, and a classification is assigned. An interdisciplinary committee will then use this information in making an assignment to the most appropriate, least restrictive placement (Sunset Advisory Commission, 1987). An effort is made to avoid placing all females and children under age 13 in an institution (TYC, 1989b).

During the fiscal year that ended August 31, 1989, 1,997 youth (1,869 males and 128 females) were committed to TYC (Appendices 6.3 and 6.4). Of these youth, 28 were sentenced offenders (i.e., youth who have been adjudicated with determinate sentences--indeed, to date only 65 youth total have been sent to TYC with determinate sentences), 200 were violent offenders, 71 were repeat offenders, 1,638 were nonviolent offenders, and 60 were CSOs (chronic serious offenders). The largest percentage of youth committed to TYC are from 15 to 16 years of age (TYC, 1989d).

It should be noted that Hispanic and black youth are overrepresented in TYC. The overrepresentation of minorities in correctional settings is not unique to Texas, is not easily explained, and is multicausal. One possible explanation is that minority populations are poorer than the white population, and more crimes tend to be committed in poorer areas. Where there is more crime, there is more likelihood of arrest. Poverty may also help explain why, once minority youth are arrested, their families and communities are less able to care for them and, therefore, why they are more apt to be adjudicated to TYC. A more complete understanding of why minority overrepresentation occurs may be helpful in developing programs to reduce such overrepresentation.

It should also be noted that some counties send a disproportionately high number of youth to TYC while other counties send a disproportionately low number (Appendix 6.5). For example, Cameron County has an estimated population of 264,000 and has 77 youth in TYC, Lubbock County has an estimated population of 226,800 and has 50 youth in TYC, and Travis County has an estimated population of 556,300 and has 50 youth in TYC. Further study is needed to determine why such disparities exist and what, if anything, should be done about them.

Institutional Care. TYC presently operates five training schools: Brownwood State School, Crockett State School, Gainesville State School, Giddings State School, and West Texas Children's Home in Pyote. Brownwood, Gainesville, and Giddings are coed. These five schools serve youth who generally have committed more serious offenses and who require a secure facility that is structured and supervised. These schools restrict youth to locked buildings (Sunset Advisory Commission, 1987). Brownwood and Giddings are surrounded by a fence, and a fence is under construction at Gainesville. There is an accredited, on-campus school at each institution. In 1987, these facilities served 2,662 youth at a daily cost of $66.15 (TYC, [1989c]) (Appendix 6.6). A sixth training school, the Evins Regional Juvenile Center in Edinburg, is scheduled to open in 1990.

Gainesville houses a chemical dependency treatment program that treats a youth for approximately five months. Because the program can accommodate only 32 participants at one time, youth move into this program as openings arise, and it stays full at all times. Upon completion of their stay in TYC, the youth go back to their home communities for follow-up contract care. Youth who have committed murders or any other crime that TYC defines as a violent crime are sent to Giddings, where they stay for a minimum of one year. In the fall of 1989 Giddings opened a substance abuse program that is similar to the Gainesville program, and it also offers an educational and day treatment program for those who do not qualify for the full program. In addition, Giddings offers an intensive program for sex offenders (many of whom have themselves been abused). It can serve 32 youth at one time, and the treatment period is a minimum of one year and usually 18 months. Youth filter into this program when there is an opening, and it is always full (TYC, [1988a]) (Orman, Interview, February 13, 1990).

In addition, TYC operates one residential treatment center, the Corsicana Residential Treatment Center. Corsicana serves delinquent youth who are emotionally disturbed, behavior- disordered, and learning-disabled. It serves approximately 80 youth at a time. In 1987, the average length of stay was 9.7 months, at an average cost per student of $127.15 per day (TYC, [1989c]). There is an on-campus school with small classes and most of the youth attend. The majority of the youth are enrolled in special education.

It is important to note that there is no facility in Texas that serves violent, mentally ill youth. If such a youth is adjudicated to TYC, the best possible placement is made working with the placement options available, but it may not be a very satisfactory placement. In some instances these youth may simply be stabilized with drug therapy, and if they have suitable homes that will take them back, they may be returned to them (Orman, Interview, November 8, 1989).

There is currently a proposal to expand Corsicana to handle violent SED adolescents. The open nature of the present facilities at Corsicana do not provide the security required for these types of students. An additional secure wing at this facility would provide a place for the evaluation and treatment of violent SED youth that is currently lacking in the TYC system (McKimmey, Intervew, October 12, 1990).

Community-Based Care

TYC's community services are provided both directly, through halfway houses and parole, and through contract care. Administered through five regional locations, the community services programs are used as an alternative to or as a follow-up to placement in a TYC institution and are less restrictive than such placement would be. Community services are of three basic types: halfway houses, contract care, and parole services.

Agency-Operated Halfway Houses. In 1987, 775 youth were served at a cost of $49.35 per day. These nine, 24-bed facilities consist of Ayres House in San Antonio, Beto House in McAllen, Dallas House in Dallas, Middleton House in Richmond, Nueces House in Corpus Christi, Schaeffer House in El Paso, Turman House in Austin, Willoughby House in Fort Worth (which is the only program for females), and Valley House in Harlingen. The youth in these facilities are involved in the community through school attendance, GED preparation, vocational training, or employment. Individual and group counseling is also provided (TYC, [1989c]).

Contract Care. In 1987, 1,613 youth were served at a cost of $49.67 per day. The levels of care provided in these programs are specialized, transitional, therapeutic, and secure (TYC, 1989b). The programs range from foster care to secure, inpatient psychiatric care. Caseworkers oversee services in this area beginning with orientation and the implementation of a contract plan, which is prepared for each TYC client at the time of admission.

Parole Services. In 1987, 4,275 youth were served at a cost of $2.49 per day. After completing a residential program, a youth is eligible to return home. At this time he or she will receive parole services, which are designed to help ease the transition from residential care to home. Most youth remain on parole until their 18th birthday, but a youth who has committed a violent offense may be on parole until the age of 21. However, if a youth does exceptionally well in all areas of parole and commits no parole violations, the youth may be eligible for an early discharge.

Parole, like the other community service programs, is administered through TYC's five regional offices. The regional directors oversee the three or four district offices that exist in each region, and each office has from one to five parole officers working out of it.

An individual case plan on each youth who is to be paroled is sent from the facility where the youth was in residence. Paroled youth have a risk/needs assessment established for them, and on the basis of this assessment a level of supervision ranging from high to low is assigned. In addition, a parole service plan is developed for each youth, and both the youth and his or her parents, where appropriate, must agree to this plan.

After an initial interview (which, if possible, is conducted in the parole officer's office), the parole officer will supervise the youth either at the parole office or in the youth's own environment.

If counseling is indicated for the youth, it may be provided in a number of ways: through the Texas Department of Health and Mental Retardation (TDMHMR), by organizations such as Austin Child Guidance, by private insurance, through privately run community programs (e.g., Youth Advocacy, Project Chance, Alcoholics Anonymous), and by school psychologists. Alternative specialized schooling is also provided when it is deemed appropriate (Smith, Interview, February 8, 1990).

To distribute parole services effectively and in a cost-efficient manner, TYC contracts with 11 county juvenile probation departments to provide the services to youth in 21 remote counties (TYC, [1989c]). Essentially TJPC provides parole services in those areas that are remote enough that it would not be possible to make efficient use of a parole officer's time.

Size

In the fiscal year that ended on August 31, 1988, TYC had 1,621.4 full-time employees (Texas Legislature, 71st Leg.). Table 6.1 shows the program population for that time period:

Table 6.1. TYC Program Population for Period 9/1/87 - 8/31/88

	Youth Served	Average Daily Population
Reception Centers	2,080	86
Training Schools	2,520	1,056
Corsicana	153	81
Halfway Houses	832	191
Contract Care	1,585*	510
Parole	4,229	1,979
Independent Living	72	16

Source: TYC, 1988c.

Note: Appendix 6.7 gives the program population figures in an expanded version for the period from September 1, 1988 to August 31, 1989.

*Approximation

At present, more youth are being adjudicated to TYC than it can comfortably manage. September of 1989 saw an unexpectedly large number of youth committed to TYC (Orman, Interview, November 8, 1989). One reason for this trend may be that local budgets have been strained by current economic conditions, and youth who have committed comparatively mild offenses and who once would have been handled locally are now being sent to TYC (Cannedy, Interview, November 11, 1989). Another reason may be the large increase in felony drug arrests (Fuchs, Interview, November 28, 1989).

Funding

TYC had an operating budget of $57,802,018 in 1989 (Texas Legislature, 71st Leg.). Of this amount, $54,420,592 (94.1 percent) came from the general revenue fund of the state; $2,590,911 (4.5 percent) came from federal funds (estimated); and $790,515 (1.4 percent) came from other funds (estimated). Approximately the same percentages apply to the budgets that have been approved for 1990 and 1991 (Tex. S.B. 222, 1989).

If a youth was receiving Aid for Dependent Children benefits before entering TYC, these benefits are discontinued while the youth is in TYC. When the youth is paroled back to the family, the family must reapply for benefits if they are to be reinstated.

ORGANIZATIONAL CONTEXT FOR SED CHILDREN

The main counseling received in the training schools is group counseling. The youth are divided into groups of from 10 to 12 which meet five times a week. The group resolves problems that arise during the day. "Youth learn responsibility for their actions by having to identify and understand any inappropriate behavior of a group member. As a group they decide on an appropriate consequence, rather than staff being solely responsible for sanctioning inappropriate behavior" (Sunset Advisory Commission, 1987, p. 145).

In an effort to learn more about the mental health of the youth committed to TYC, a recent search was made of the files of 2,772 youth in TYC's care and the data were categorized according to diagnosis (Appendix 6.8). The final sample size of 1,282 youth represents all the youth in institutions and halfway houses, but the master files for all youth on parole and in contract care were not readily accessible. Furthermore, because of time constraints, youth who had multiple diagnoses were not separated out. TYC believes the figures to be representative of the type of mental health issues dealt with by their agency. However, some of the figures may be lower than what they are in actuality because of the lack of diagnoses in the file. For example, it is known that many youth in TYC have been abused, but the "Abused Child" designation under Axis III, DSM-III-R, is not normally designated by the TYC physicians (TYC, 1990).

This collection of data represents a significant step forward in learning the specific nature of the emotional health of TYC's clients. Prior to the compilation of this data, with the exception of the youth sent to Corsicana, no figures were kept on SED youth. All of the youth in Corsicana are considered seriously emotionally disturbed. In 1989, the average population of Corsicana was 88. However, in the opinion of the chief of counseling at TYC, all the youth in the residential training schools would benefit from therapeutic, psychological counseling (Orman, Interview, November 8, 1989).

If a youth is severely disturbed, TYC will fund the youth's placement in a residential treatment center or a psychiatric hospital. Contract care is provided for approximately 107 severely disturbed youth (TYC, 1990, p. 1). However, if a youth is assaultive or psychotic, appropriate placement is very difficult, if not impossible.

Three memoranda of understanding exist between TDMHMR and TYC. One is on the subject of assisting TYC in providing services for mentally retarded youth. The second addresses the issue of reducing duplication and improving the coordination of services to children with multiagency needs (Austin and Michie, 1989, pp. 41-42).

The third memorandum, authorized by SB 33, 70th Texas Legislature (see Appendix 8.4), began as a model program of TDMHMR and a local mental health authority for TYC youth in need of psychiatric hospitalization. While this program is now statewide, the original memorandum provided for coordination between Austin State Hospital (ASH), Austin-Travis County MHMR Center, Central Texas MHMR Center (Brownwood), and ASH Community Services with TYC facilities in Giddings and Brownwood, the Truman Halfway House in Austin, and the Brownwood Reception Center. The object of this coordination was to provide psychiatric services for severely assaultive, emotionally distrubed youth in need of long-term treatment in a maximum security environment. The program is comprised of five steps which include referral, assessment, staffing, tratment and aftercare planning (TYC/TDMHMR, n.d., p. 1).

The training schools offer educational and vocational programs, family involvement, and individual and group counseling. With the exception of Giddings, which has a psychologist with a Ph.D., each of the schools has one full-time master's-level psychologist. The budget for 1990 does include funds to hire two more Ph.D.-level psychologists, with two more budgeted for 1991 (TYC, [1988a]). However, it is difficult to find psychologists with these qualifications who want to work for TYC because the amount that has been budgeted for their salaries is not competitive with the income from other career opportunities. In addition, each school has the services of a psychiatrist 8 hours a week, except for Brownwood, which has a psychiatrist 16 hours a week because the reception center is located there. As their hours are so limited, the psychiatrists can do little but dispense orders for medication, except for Brownwood, where they also work on intake evaluations. In other words, the psychiatrists do not have time to do much, if any, counseling.

Although the youth in the training schools receive transitory counseling (that is, counseling for particular problems as they arise), they do not as individuals receive the amount of therapeutic counseling they need. A youth could go through the program without receiving any in-depth therapeutic care or psychological counseling (Orman, Interview, November 8, 1989). If youth are not effectively rehabilitated (and the effectiveness of rehabilitation usually depends on therapeutic counseling), they are apt to become recidivists.

RECIDIVISM

Within TYC

Recidivism is defined by TYC as

> . . . the percentage of youth released to home who within three years have been recommitted, revoked to a TYC training school, or admitted to the Texas Department of Corrections. The recidivism rate for each program type or facility is calculated based on members of a three-year cohort released between July 1, 1985 and June 30, 1986, whose last placement was at that program type or facility. (TYC, 1989d, p. 20)

At the end of FY 1989, the reincarceration rate after three years was 39 percent, of which 44.5 percent came from placements in the training schools, 25.5 percent from the halfway houses, and 31.1 percent from contract care (Appendix 6.9). These figures are not surprising due to the different types of students placed in each type of care. It is important to note, however, that because of reporting difficulties, these figures are probably an underestimation of the actual figures (TYC, 1988b, pp. i-ii). Moreover, care must be taken in trying to compare the various programs and individual schools because in some cases the size of the cohort is so small as to introduce substantial difficulties in making a significant statistical analysis.

An effort was made for the purposes of this study to obtain the figures for the number of people who have ever been in TYC that are now in TDC. It was learned that such figures have not been compiled, and even if one were willing to undertake a records search to obtain them, they would be of dubious worth, as previous commitments to TYC are self-reported.

National Perspective

The issue of recidivism is a national issue. It is important for a number of reasons, including the fact that the more often an individual is arrested as a juvenile, the more likely that individual will have a long, active criminal career as an adult (Greenwood and Zimring, 1985, p. vii). This fact translates to very large social and economic costs.

Five primary predictor categories have been found to correlate with chronic delinquent behavior.

1. Family characteristics. These include low income, a history of mental illness in the mother, many siblings, and siblings with criminal records.
2. Biological or physical impairment. These include deficits and/or impairment of the central nervous system and some minor birth abnormalities.
3. Familial experience. These include lack of love and affection displayed by the parents toward the child, failure to supervise the child's behavior, and an inconsistent discipline and reward system.
4. Predelinquent behavioral flags. These vary with age; for chldren from 6 to 12 years of age they include disobedience, lying, stealing, excessive aggression, daring behavior, and truancy; for older children they include heavy drinking or smoking, the use of drugs, fighting, and sexual promiscuity.
5. Criminal acts. There is a strong correlation between future criminal behavior and the age of onset of criminal acts and their frequency and seriousness (Greenwood and Zimring, 1985, pp. 9-11) .

Because it is very difficult to break the cycle of recidivism once it has become established and because it is extremely unlikely that " . . . any individual who was never arrested as a juvenile will become a chronic offender as an adult" (Greenwood and Zimring, 1985, p. 12), it is important to look at early intervention strategies. As Peter Greenwood and Franklin Zimring point out in their Rand Corporation report, One More Chance The Pursuit of Promising Intervention Strategies for Chronic Juvenile Offenders,

> Prediction studies suggest that future chronic offenders can be identified at about age 13 on the basis of their early offenses, school record, and their family's characteristics and behavior. However, coercive programming under the formal jurisdiction of the juvenile court is limited by both legal and practical concerns to those juveniles who have been found guilty of real criminal acts. Preventive programming for high-risk youths who have not yet been found to have committed criminal acts must take place within the educational system or community. Programs that show promise of reducing the risk of later delinquency for high-risk children include early education programs such as Head-start, parent training programs such as that developed by the Oregon Social Learning Center, and educational programs and practices identified in the "effective schools" and "safe schools" literature. All of these programs focus on high-risk populations, are acceptable to parents, and show evidence of effectiveness. (1985, p. 69)

CURRENT ISSUES OF CONCERN

In a yet unpublished study by Texas A & M University, it was found that approximately 74 percent of the youth in TYC could be classified as chemical (drug or alcohol) abusers. Of this 74 percent, approximately 42 percent are considered to be very serious abusers (Orman, Interview, November 8, 1989). In the three-year period from 1986 to 1988, commitments to TYC for drug offenses were as follows: 1986, 3 percent; 1987, 4 percent; and 1988, 5 percent (TYC, 1989e). Although chemical dependency may not be the stated reason for many commitments to TYC, it would seem to be an underlying cause. Furthermore, TYC is caring for more youth "who are violent and have few inhibitions about assaulting others. This disturbance can be attributed to factors such as drug and inhalant abuse" (TYC, [1990], p. 2). These are just two of the reasons to improve the programs aimed at preventing substance abuse.

A joint effort has been made with the Texas Commission on Alcohol and Drug Abuse (TCADA) to obtain legislatiye funding, and, as a result, drug and alcohol treatment is being expanded at TYC (TYC, [1990], p. 2).

To improve its effectiveness in working with substance abusers, TYC has suggested strategies of developing (1) a typology model of substance abusers, (2) a screening and assessment methodology, and (3) a recommended treatment approach for each type of abuser. In addition, TYC wants to coordinate with other agencies in the area of substance abuse treatment and planning (TYC, 1989f).

In the 1986 staff report on TYC to the Sunset Advisory Commission, the following issues were discussed and are still areas of interest and concern:

1. Parole supervision. A need was perceived to provide more parole supervision through local probation departments. A statute exists to contract with any of the probation departments to provide parole services. The result could be less expensive parole services that are provided closer to the youth's home. This recommendation has been implemented in some areas of the state. Whether further implementation is advisable is a matter for TYC to consider.

2. Halfway-house services. The possibility of increasing contracting for halfway-house services through the private sector was explored. It may be as effective to contract for the care of youth at this level, and it may be somewhat more cost efficient (although this point would seem to be debatable). It does have the advantage that, on the average, the youth can be placed closer to home.

3. Prevention. The need to increase efforts to prevent delinquency was discussed by the Texas Sunset Advisory Commission, which points out, "There appears to be a strong correlation between delinquency and problems in school, physical and sexual abuse, drug and alcohol abuse, and running away from home" (1986, p. 77). The need for early intervention regarding youth with emotional disturbances is an immediate priority of TYC. TYC recognizes the need to provide crisis intervention, with the goal of keeping youth in their home when possible. Although TYC does not have sufficient resources to meet this need, an interagency effort to work with this population through local mental health services is one possible approach to this problem (TYC, 1990).

In its report the Sunset Commission made three recommendations. The first is that the Communities in Schools Program be expanded to distribute services to a greater number of potential dropouts. The report notes that approximately 85 percent of all Texas Department of Corrections inmates were never graduated from high school. The second recommendation is that some of the funding for adult drug and alcohol abuse be shifted to increase comparable services to youth. The third is that the Texas Department of Human Services runaway programs be expanded by the state (Texas Sunset Advisory Commission, 1986, pp. 75-84).

Another problem is that child psychiatrists are very highly paid in the private sector, and, therefore, state agencies and nonprofit organizations, which are unable to compete for their services, often have to do without (Mental Health Association in Texas, 1989). Jay Lindgren, deputy executive director of TYC, points out that TYC is badly in need of stronger clinical services and has trouble getting and keeping Ph.D.-level psychologists (quoted in Keir, 1989). Certainly it will be difficult for TYC to rehabilitate its clients effectively if the people who are most qualified to do the rehabilitating are unavailable.

Currently TYC and TDMHMR are requesting joint funding to provide specialized care for violent mentally disturbed youth (TYC, 1990, p. 3). This group of youth includes both youth who have been adjudicated to TYC and youth who have not committed an act to cause them to have been adjudicated to TYC.

TYC is also currently applying to have its facilities accredited by the American Correctional Association. Accreditation is valuable in its own right and also reenforces the progress that has been made since Morales v. Thurman. At present none of the TYC facilities are accredited, but it is anticipated that two halfway houses, Ayres House and Willoughby, will be accredited in the spring of 1990 and two more, Dallas House and Turman House, will be accredited in the fall of 1990. For accreditation, a general operating procedures manual that documents and implements established procedures in each institution is required. It is also necessary to meet life safety codes, such as building and fire codes, as part of the accreditation process (Taylor, Interview, November 7, 1989).

MODEL PROGRAMS

Several states have developed programs that are considered models within the juvenile justice system. Three in Massachusetts, Utah, and Florida will be considered here.

Massachusetts

In 1972, the Department of Youth Services of Massachusetts embarked on a program that resulted in a system in which 90 percent of its youth are presently served in small, nonsecure programs. Indeed, approximately two-thirds of the youth within its system reside at home. Those youth residing at home are served by caseworkers or are enrolled in nonresidential programs which include services ranging from educational to vocational. These youth receive highly individualized care under the Outreach and Tracking and Tracking Plus programs. Youth in these programs are assigned an outreach worker whose case load does not exceed six clients.

Tracking Plus is designed for youth who fail to adjust adequately to life in the community and may require a short period of stabilization prior to returning home. This stabilization takes place in residential facilities that are small and highly structured.

Five percent of the youth are served in foster homes. These are youth who do not require a great amount of structure and for whom home placement is not appropriate.

The remaining 30 percent are placed in a residential facility. These range from the Homeward Bound program, to group homes, to secure treatment facilities. The Homeward Bound program is also known as the Forestry Camp, and it offers a wide variety of outdoor experiences at various sites throughout the state.

The group homes are structured but unlocked residential settings for youth who present little or no security risk.

The secure treatment facilities are used for those youth who are violent and/or who have severe emotional problems. To identify these youth, a three-member panel uses a detailed classification system to determine whether a youth belongs in the secure treatment system and, if so, how long such a placement should be and which facility is most appropriate. The panel is guided by a complete history, an assessment of the views of the involved parties, and a detailed classification grid, in which the offenses committed by each youth are ranked according to their severity. Based on this assessment, the youth will be assigned to a secure treatment facility for a corresponding range of proposed terms. The classification grid has provided a means for fair and consistent decisions, and it has given the judicial system confidence in the placement decisions made by the Department of Youth Services. In addition, the classification grid system has been a great help in planning future resource needs.

A secure 15-bed treatment program, the Butler Center, is designed to serve youth identified as severely emotionally disturbed, whose crimes may include violence and/or sexual deviancy. This program, which is designed to help youth confront their problems, consists of an intensive clinical component with individualized and family therapy (Loughran, n.d, p. 17).

The Violent Offender Project, which services serious offenders, consists of the following three phases: (1) secure treatment, (2) nonsecure residential treatment, and (3) return to the community with intense casework supervision. The program has been shown to be effective in curtailing delinquency in the youth who complete it. In addition, the youth who complete it are more apt to continue in an educational program and to obtain better jobs than youth who are placed in a secure setting but are not part of the project.

A measure of the success of the Massachusetts program is the fact that 35 percent of the commitments to the state's Department of Corrections in 1972 had previous experience with its Department of Youth Services, but by 1985 this figure had dropped to 15 percent (Loughran, n.d., p. 18).

Utah

Utah's program for juvenile offenders is similar to that in Massachusetts and, indeed, relied heavily on the Massachusetts model in its conception. It has moved from a system in which incarceration was the primary method of handling youthful offenders to a system in which incarceration is used only very sparingly and community-based programs are the primary method of care. For example, from 1976 to 1986 Utah reduced its number of secure beds from 450 to 60 while increasing its community program slots from 0 to 250.

Utah's community-based programs, which are provided both by the private sector and county governmental entities, include

1. Family treatment. The state contracts with highly skilled family therapists to provide services tailored to the needs of each family.
2. Tracking programs. This is a nonresidential program in which each youth receives daily contact and surveillance.
3. Special service programs. These include programs for drug and alcohol abuse, career development, and alternative education.
4. Education. This program includes special education, tracking, counseling and support programs.

5. Proctor advocate. A "tracker" (professional staff member) is assigned to a youth who lives in a single- adult home.

6. Group homes. These homes vary in type of staffing and number of youth, but all involve residential treatment and supervision.

7. Specialized residential programs for emotionally disturbed youth who would otherwise be in state hospitals.

8. Drug and alcohol outpatient services. This program serves both individuals and groups and includes tracking and daily contact. (Van Vleet, Rutherford, and Schwartz, n.d.)

Utah's program has resulted in more individualized and humane treatment of youth, lower recidivism rates (a 66 percent drop in the number of new arrests in the year following their commitment to the Youth Corrections program), better protection of the public, and lower cost to the public.

Florida

As in Texas, the impetus for change in the juvenile justice system of Florida was a class action lawsuit, Bobby M. v. Martinez, filed in 1983. In working to improve its system, two problems kept reappearing: Florida had a recidivism rate it considered unacceptable, and institutional care was significantly more expensive than community-based alternatives. In response to the lawsuit and the two aforementioned problems, Florida developed a four-part program (Streit, 1988, pp. 37-39).

The first objective was to confront the need for effective programming. This component of the program established the following priorities. Its first priority was to deal appropriately with serious and violent juvenile offenders. Florida plans an intense treatment and supervision program of approximately 18 months duration in small centers to serve these offenders. A second priority was to develop special treatment programs for youth with special needs, especially in the areas of mental health, sex offenses, and substance abuse. The third priority was to establish high quality and effective programming for "the entire population of youthful offenders utilizing what we have learned from past experience and research." (Streit, 1988, p. 37). The purpose here is to enable public policymakers to make those difficult decisions that must be made to maximize the investment of resources in the most cost-effective manner.

The second objective was to establish a workable assessment, classification, and placement process. This includes both assessing the needs of the individual youthful offender, developing a plan for treatment, and establishing the most appropriate placement.

The third objective was to stop overreliance on deep-end training school programs. That is, there was a goal to make the least secure placement consistent with the youth's and the public's safety. To implement this and to ensure accountability, Florida has committed itself to a case management system.

The fourth objective was to do something about the reality of recidivism. This recognizes that even if a juvenile is confined for a period of time, he or she will ultimately have to reenter society. For this reentry to be successful the youth will need support from the community, including a strengthened family and improved educational and employment opportunities.

In suggesting what another state should look at in the allocation of its resources to address youth crime, Samuel Streit, the director of Children, Youth, and Families in the

Department of Health and Rehabilitation Services for the state of Florida, makes the following suggestion:

> In particular, prevention and early intervention programs that focus upon family and school problems utilizing community-based resources ... must receive greater financial assistance if we are to maximize the value of the public's investment in this system. (1988, p. 41)

CONCLUSIONS

The February 16, 1990, edition of the Journal of the American Medical Association contained an article by its Council on Scientific Affairs entitled "Health Status of Detained and Incarcerated Youths." This article states

> ... Psychiatric disorders, such as learning disabilities, conduct disorder, and depression appear to be significantly more prevalent than expected among incarcerated youths. These may be related to organic (biological), ecological (family, school, peers, etc), and psychological factors, or an interaction of all three. Past or present symptoms that meet a diagnostic criterion for major depression have been found in approximately 20% of juveniles in correctional facilities. In a study that compared juveniles in detention with a group of adolescents in a family practice clinic, 11% of the former were clinically depressed, compared with 4% of the latter. (p. 988)

In many cases it is possible and not difficult for the trained observer to identify conduct disorders and learning disabilities while children are still quite young and more easily controlled or remediated. Learning disabilities may often be identified before a child enters school. Conduct disorders are usually apparent in male children by ages 7 or 8, although they usually appear somewhat later in female children. While not ignoring that some of the depression experienced by youth in correctional facilities may be due to the fact of their detention, nonetheless, depression may result in antisocial acts, and so may be the cause of detention. Here again, the trained observer is often able to identify depression in its early stages while it is still "manageable."

In short, it would seem that early identification and treatment of learning disabilities, conduct disorders, depression, and many of the conditions listed in the DSM III-R diagnoses (Appendix 6.8) would result in some reduction of the number of youth adjudicated to TYC. It would also seem that the costs of early identification and treatment, both absolute dollar and human, would be less than those of treating a fully developed psychiatric disorder within the juvenile justice system. However, the lack of early identification and treatment is not the responsibility of TYC. Indeed, it could be said that all too often it is the responsibility of TYC to "pick up the pieces" and to try to repair a young life once the rest of society has failed that young life.

Unfortunately, TYC must often try to perform its responsibility without the basic resources it needs to do so. To the extent that youth who have psychiatric diagnoses are adjudicated to TYC, the need for hiring Ph.D.-level psychologists and child psychiatrists to care for them is underscored. The problem is that the state of Texas will not pay wages sufficient to attract the caliber of psychologists TYC needs, and there are not enough child psychiatrists to go around no matter how much the state is willing to pay.

In spite of these constraints, TYC is doing many things right. It is expanding its chemical dependency programs. It continues to move in the direction of least restrictive care as close to home as possible. It provides a continuum of care through its parole services. It is aware of its recidivism problem and is doing what it can to lessen it. And it provides what counseling it can with the resources available to it.

Appendix 6.1. Texas Youth Commission Board Members

CHAIRMAN:

Mr. Larry York, Managing Partner
Baker & Botts
1600 San Jacinto Tower
Austin, Texas 78701
Term Expires 8/31/91

VICE-CHAIRMAN:

Mr. Comer Cottrell, President
Pro-Line Corporation
2121 Panoramic Circle
Dallas, Texas 75212
Term Expires 8/31/91

MEMBERS:

Mr. Gary Compton, Attorney
Whittenbury, Whittenbury & Schachter
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500 S. Taylor
Amarillo, Texas 59101
Term Expires 8/31/91

Mr. Kenneth George
Epic Healthcare Group
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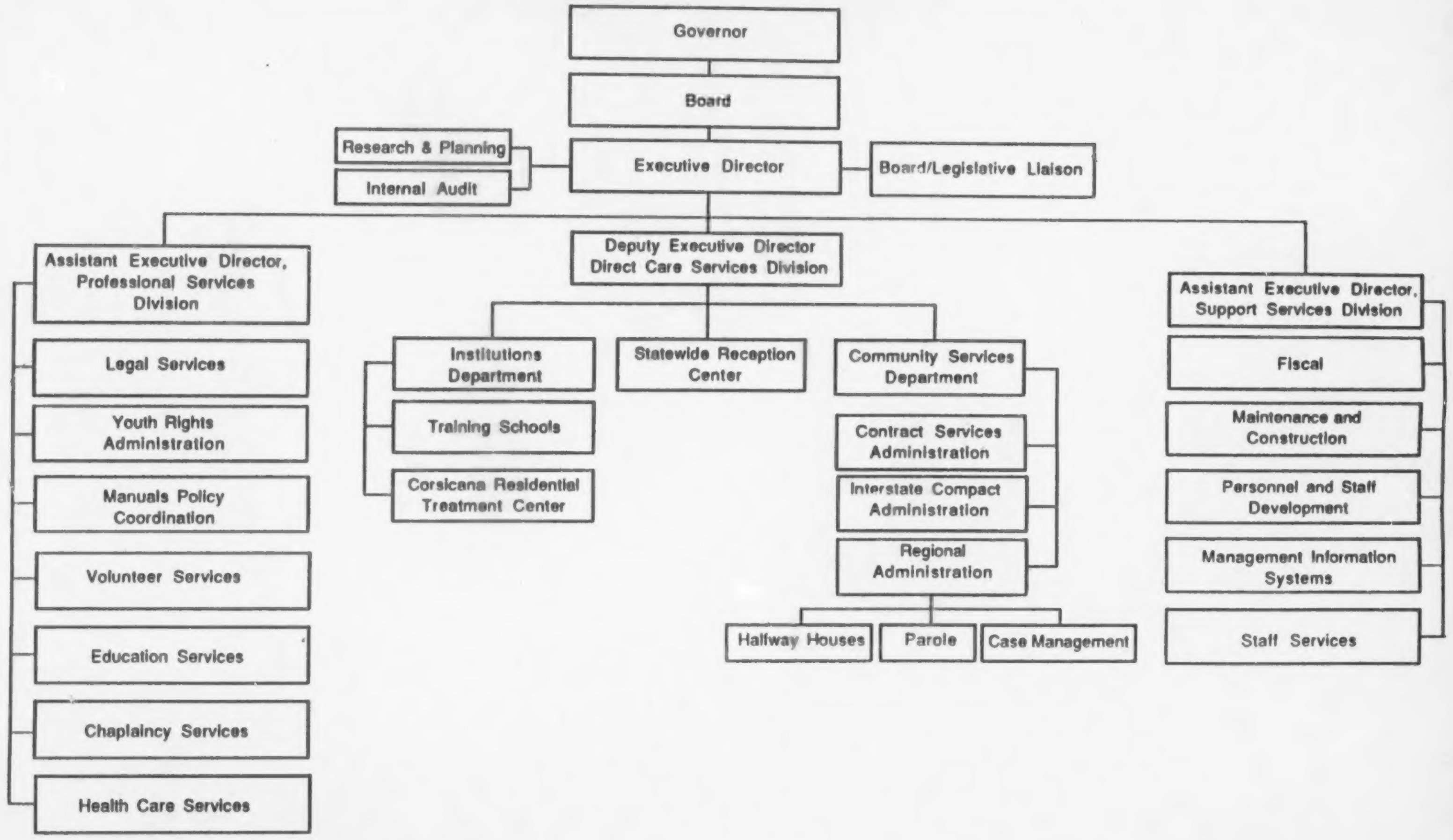
Term Expires 8/31/91

Reverend Floyd N. Williams, Sr.
Antioch Baptist Church
5902 Beall
Houston, Texas 77091
Term Expires 8/31/91

Ms. Marilla B. Wood
Texas Commerce Bank
Private Banking Center
700 Lavaca
Austin, Texas 78701
Term Expires 8/31/95

APPENDIX 6.2 Texas Youth Commission Agency Organization Chart


Governor
Board
Research & Planning
Internal Audit
Executive Director
Board/Legislative Liaison
Assistant Executive Director, Professional Services Division
Legal Services
Youth Rights Administration
Manuals Policy Coordination
Volunteer Services
Education Services
Chaplaincy Services
Health Care Services
Deputy Executive Director Direct Care Services Division
Institutions Department
Training Schools
Corsicana Residential Treatment Center
Statewide Reception Center
Community Services Department
Contract Services Administration
Interstate Compact Administration
Regional Administration
Halfway Houses
Parole
Case Management
Assistant Executive Director, Support Services Division
Fiscal
Maintenance and Construction
Personnel and Staff Development
Management Information Systems
Staff Services

Source: Texas Youth Commission, Office of the Executive Assistant, 1989.

Appendix 6.3 Student Characteristics of Commitment to TYC for Period 9/1/88 - 8/31/89

	----SEX---		------------OFFENDER CLASS------------					-----RACE/ETHNICITY-----				----CITIZENSHIP----			
	M	F	Sen-tenced	Violent	CSO	Repeat	Non-violent	Black	White	Hisp.	Other	USA	Mex.	Other	TOTAL
AGE	1869	128	28	200	60	71	1638	722	518	744	13	1868	117	12	1997
10	3	0	0	1	0	0	2	1	1	1	0	2	1	0	3
11	9	0	0	3	0	0	6	3	1	5	0	6	3	0	9
12	25	3	0	1	1	0	26	10	7	11	0	25	3	0	28
13	122	13	3	14	1	2	115	40	32	63	0	119	16	0	135
14	320	33	4	37	7	6	299	112	71	168	2	325	27	1	353
15	537	41	9	45	21	21	482	205	165	204	4	543	31	4	578
16	736	35	9	82	27	38	615	310	205	250	6	734	31	6	771
17	117	3	3	17	3	4	93	41	36	42	1	114	5	1	120
CITIZENSHIP	1869	128	28	200	60	71	1638	722	518	744	13				1997
USA	1744	124	26	191	57	70	1524	720	517	623	8		N/A		1868
Mexican	113	4	2	8	2	1	104	0	0	117	0				117
Other	12	0	0	1	1	0	10	2	1	4	5				12
RACE/ETHNICITY	1869	128	28	200	60	71	1698								1997
Black	679	43	12	70	19	30	591								722
White	464	54	5	53	14	14	432			N/A					518
Hispanic	713	31	11	75	27	25	606								744
Other	13	0	0	2	0	2	9								13
OFFENDER CLASS	1869	128													1997
CSO	59	1													60
Sentenced	28	0				N/A									28
Violent	194	6													200
Repeat	70	1													71
Non-violent	1518	120													1638

Non-violent category includes 2 VCP offender.

Source: TYC, 1989d, p. 4.

Appendix 6.4 Student Characteristics in Population at 8/31/89

	---SEX---		------RACE/ETHNICITY------				----------OFFENDER CLASSIFICATION----------						
	M	F	Black	White	Hisp.	Other	Snt.	Viol.	Rep.	CSO	VCP	Viol	TOTAL
TOTAL	3602	330	1234	1047	1623	28	46	577	223	164	32	2890	3932
RECEPTION CENTERS	88	6	38	19	37	0	0	9	0	1	0	84	94
TRAINING SCHOOLS	913	36	343	233	367	6	41	327	13	110	1	457	949
CORSICANA RTC	71	17	19	56	12	1	1	14	1	0	1	71	88
COMMUNITY	600	82	245	197	236	4	1	26	19	8	10	618	682
Halfway Houses	179	17	73	42	80	1	1	13	3	4	1	174	196
Contract Care	421	65	172	155	156	3	0	13	16	4	9	444	486
HOME	1930	189	589	542	971	17	3	201	190	45	20	1660	2119
Family	1915	183	584	533	964	17	3	197	188	45	19	1646	2098
Indep. Living	15	6	5	9	7	0	0	4	2	0	1	14	21
Detail:													
Giddings	259	11	97	72	100	1	41	228	0	0	0	1	270
Brownwood	162	25	65	32	90	0	0	37	4	33	1	112	187
Crockett	87	0	44	20	21	2	0	18	1	13	0	55	87
Gainesville	238	0	116	84	36	2	0	22	4	37	0	175	238
West Texas	167	0	21	25	120	1	0	22	4	27	0	114	167
Ayres	20	0	3	9	8	0	0	6	0	0	0	14	20
Dallas	25	0	13	8	4	0	1	1	3	0	0	20	25
Mcallen	21	0	5	2	14	0	0	0	0	1	0	20	21
Middleton	18	0	14	2	1	1	0	1	0	0	0	17	18
Nueces	26	0	10	6	10	0	0	0	0	2	0	24	26
Schaeffer	26	0	9	4	13	0	0	1	0	1	0	24	26
Turman	23	0	8	3	12	0	0	1	0	0	0	22	23
Valley	20	0	6	1	13	0	0	1	0	0	0	19	20
Willoughby	0	17	5	7	5	0	0	2	0	0	1	14	17

Source: TYC, 1989d, p. 6.

APPENDIX 6.5 Commitments/Recommitments by Region and County for Period 9/1/88 - 8/31/89

		2nd HALF	FY 89 YTD	PERCENT
By	Region:			
	EAST	340	627	31.40%
	NORTH	325	574	28.74%
	CENTRAL	180	336	16.83%
	WEST	136	259	12.97%
	SOUTH	101	201	10.07%
	TOTAL	**1082**	**1997**	**100.00%**
By	County:			
	HARRIS	248	446	22.33%
	DALLAS	128	219	10.97%
	TARRANT	94	168	8.41%
	EL PASO	53	112	5.61%
	BEXAR	63	97	4.86%
	CAMERON	28	49	2.45%
	HIDALGO	19	44	2.20%
	MCCLENNAN	24	37	1.85%
	TRAVIS	13	37	1.85%
	NUECES	14	36	1.80%
	GALVESTON	16	35	1.75%
	BRAZORIA	14	30	1.50%
	LUBBOCK	23	27	1.35%
	WEBB	8	19	0.95%
	FORT BEND	15	18	0.90%
	JEFFERSON	7	18	0.90%
	MIDLAND	10	17	0.85%
	MONTGOMERY	6	17	0.85%
	SAN PATRICIO	11	19	0.95%
	BELL	12	16	0.80%
	BROWN	2	16	0.80%
	WICHITA	8	15	0.75%
	JOHNSON	8	13	0.65%
	UVALDE	4	13	0.65%
	COLLIN	8	12	0.60%
	TAYLOR	6	12	0.60%
	WILLIAMSON	7	12	0.60%
	ANGELINA	6	11	0.55%
	BASTROP	9	11	0.55%
	SMITH	8	11	0.55%
	GRAYSON	5	10	0.50%
	POTTER	2	10	0.50%
	All other counties (committing fewer than 10 during FY)	203	390	19.53%

Source: TYC, 1989d, p.2.

Appendix 6.6. Cost, Population, and Employees By Institution

Brownwood State School

Avg. Budgeted Cost Per Day	$	78.45
Total Budget	$	5,866,283.00
Budgeted Population		192
Average Daily Population		201
Current Daily Population		253
Number of Employees		204

Corsicana Treatment Center

Avg. Budgeted Cost Per Day	$	111.76
Total Budget	$	4,001,776.00
Budgeted Population		88
Average Daily Population		86
Current Daily Population		88
Number of Employees		140

Crockett State School

Avg. Budgeted Cost Per Day	$	97.02
Total Budget	$	3,785,656.00
Budgeted Population		96
Average Daily Population		98
Current Daily Population		120
Number of Employees		145

Gainsville State School

Avg. Budgeted Cost Per Day	$	71.76
Total Budget	$	7,080,661.00
Budgeted Population		256
Average Daily Population		251
Current Daily Population		311
Number of Employees		248

Giddings State School

Avg. Budgeted Cost Per Day	$	72.74
Total Budget	$	7,398,645.00
Budgeted Population		256
Average Daily Population		268
Current Daily Population		270
Number of Employees		268

West Texas Children's Home

Avg. Budgeted Cost Per Day	$	82.78
Total Budget	$	5,206,902.00
Budgeted Population		256
Average Daily Population		170
Current Daily Population		195
Number of Employees		200

Source: Texas Youth Commission, October 1989.

Appendix 6.7 Program Population for Period 9/1/88 - 8/31/89

	--Number Admissions--		Number	Number	Number		--Average Length of Stay--	
	Permanent	Temporary	Served	Released/ Discharged	Discharged Only	ADP	Program Type	Initial Residential
RECEPTION CENTERS	2025	618	2370	2018	1	88	0.54 mos.	--
TRAINING SCHOOLS	2024	151	2914	2238	70	1024	6.21 mos.	8.77 mos.
CORSICANA RTC	94	7	174	90	2	84	11.90 mos.	17.37 mos.
COMMUNITY	2370	832	2665	2410	177	721	4.23 mos.	8.43 mos.
Halfway Houses	799	140	948	797	66	185	3.49 mos.	7.06 mos.
Contract Care	1571	692	1717	1613	111	536	4.64 mos.	9.12 mos.
HOME	2994	225	4217	2788	1687	1742	8.66 mos.	
Family	2929	225	4126	2724	1650	1724	8.71 mos.	--
Indep. Living	65	0	91	64	37	18	4.14 mos.	--
TOTAL	12501	2058	16557	12332	3624	5401		8.82 mos.
Detail:								
Giddings	199	78	497	207	12	269	13.13 mos.	13.03 mos.
Brownwood	581	27	757	636	19	215	4.19 mos.	9.20 mos.
Crockett	228	9	302	249	8	98	6.11 mos.	9.42 mos.
Gainesville	691	27	875	781	20	276	5.18 mos.	6.90 mos.
West Texas	325	10	483	365	11	167	6.09 mos.	7.51 mos.
Ayres	109	15	131	101	27	16	2.22 mos.	NA
Dallas	97	20	123	91	4	22	3.93 mos.	7.17 mos.
Beto	95	14	131	101	9	22	3.42 mos.	6.50 mos.
Middleton	85	5	109	84	0	22	3.97 mos.	7.08 mos.
Nueces	101	27	136	98	5	21	3.28 mos.	8.51 mos.
Schaeffer	91	11	118	90	4	22	3.26 mos.	8.02 mos.
Turnan	90	27	128	93	8	21	3.64 mos.	5.41 mos.
Valley	80	15	115	88	4	22	3.57 mos.	6.69 mos.
Willoughby	51	6	67	51	5	16	4.63 mos.	7.83 mos.

Source: TYC, 1989d, p. 9.

Appendix 6.8. Mental Health Report

DSM III-R: Axis I	Institutions	HWH Regional Halfway Houses	Total
Adjustment Disorder:			
Depressed	19	90	109
Anxious	4	2	6
Disturbance of Conduct	92	80	172
w/disturbance of emotions and conduct	54	23	77
w/mixed emotional features	25	3	28
w/work inhibition	2	2	4
Adolescent Antisocial Behavior	75	34	109
Alcohol:			
Abuse	103	76	179
Dependence	12	6	18
Amphetamine:			
Abuse	12	8	20
Dependence	2	1	3
Anxiety Disorder NOS	1	2	3
Attention Deficit Disorder:			
w/hyperactive	133	51	184
Moderate or Residual	12	61	73
Avoidant Disorder of Adolescence	2	3	5
Atypical Psychosis	11	7	18
Bipolar Disorder:			
Depressed	1	10	11
Manic	1		1
Atypical	3	1	4
NOS	8		8
Mixed	6	1	7
Brief Reactive Psychosis	2		2
Cannabis:			
Abuse	122	74	196
Dependence	34	47	81
Cocaine:			
Abuse	38	31	69
Dependence	23	1	24
Cyclothymia	4	2	6
Depersonalization	1		1
Delusional Disorder		1	1
Depressive Disorder	26	24	50

Appendix 6.8. Mental Health Report (Continued)

DSMIII-R: Axis I	Institutions	HWH Regional Halfway Houses	Total
Dissociative Disorder		1	1
Dysthymia	155	154	309
Eating Disorder	2		2
Explosive Disorder:			
Single	2	1	3
Intermittent	21	8	29
Frotterurism	1		1
Functional:			
Encopresis	4	3	7
Enuresis	22	17	39
Gender Identity Disorder Adolescence	5	1	6
Hallucinogen:			
Abuse	14	4	18
Dependence	1		1
Identity Disorder	22	13	35
Impulse Control Disorder	10	6	16
Inhalant:			
Abuse	37	31	68
Dependence	10	5	15
Major Depression:			
Mild	39	19	58
Atypical	8	1	9
Single Episode	5		5
Nicotine:			
Dependence	4		4
Occupational	10		10
Opiad:			
Abuse	2		2
Dependence	1		1
Oppositional Defiant Disorder	59	65	124
Organic Disorder	16	1	17
Organic Personality Disorder	11	1	12

Appendix 6.8. Mental Health Report (Continued)

DSMIII-R: Axis I	Institutions	HWH Regional Halfway Houses	Total
Other Interpersonal	10	9	19
Over Anxious Disorder	18	19	37
Panic Disorder	3	1	4
Paraphilia	2		2
Parent-Child	22	13	35
Pedophilia	17		17
Phase of Life	15		15
Phencyclidine (PCP) Abuse	1		1
Polysubstance:			
Abuse	49	63	112
Dependence	55	18	73
Post-Traumatic Stress Disorder	40	5	45
Psychoactive Substance:			
Abuse	42	1	43
Dependence	1		1
Psychotic Disorder	3	1	4
Pyromania	3		3
Schizoaffective		2	2
Schizophrenia:			
Paranoid		2	2
Undifferentiated	5	1	6
Schizophreniform Disorder	4	1	5
Separation Anxiety	7	1	8
Sexual Disorder:			
NOS	3		3
Sadism	4		4
Simple Phobia	3		3
Sleepwalking	1		1
Undifferentiated Substance:			
Abuse	92	88	180
Dependence	14		14

Appendix 6.8. Mental Health Report (Continued)

DSMIII-R: Axis I	Institutions	HWH Regional Halfway Houses	Total
Psychosis		2	2
Stuttering	6	2	8
Tic Disorder	2		2
Tourette's Disorder	3		3
Undifferentiated Attention Disorder	1		1
Uncomplicated Bereavement	2	3	5
Physical Trauma		1	1
Abused Child	1	3	4
Undescended Testes		1	1
Severe Scarring		2	2
Unspecified Head Injury	2	2	4
Pregnancy		3	3
Heart Murmur		2	2
Insomnia		1	1
Seizure Disorder	18	5	23
Acne		4	4
Soft Neurological	1	3	4
Deaf		1	1
Asthma	2	1	3
Obesity	7	1	8
Fetal Alcohol/Drug Syndrome	3	2	5
Ulcer	1		1
Diabetes	1		1
Allergies	2		2
Sickle Cell Traits	1		1
Cardiac Arhythmia	1		1

Appendix 6.8. Mental Health Report (Continued)

DSMIII-R: Axis III	Institutions	HWH Regional Halfway Houses	Total
Temporal Lobe Epilepsy	1		1
Brain Damage	5	2	7
Other:			
Speech	2	3	5
Hearing Loss	6	2	8
Hemophilia	1		1

Source: Attached to Texas Youth Commission, Children's Interagency Planning Process, 1990. No page numbers.

Appendix 6.9. Percentage Reincarcerated
FY 1988 Cohort

	# in Cohort	Within 1 Year	Within 2 Years	Within 3 Years
Training Schools	1694	22.9	37.0	43.2
Brownwood	381	24.7	37.3	43.0
Crockett	196	29.1	42.9	51.0
Giddings	273	12.1	26.7	33.7
Gainesville	476	22.7	40.8	47.7
West Texas	368	26.1	36.1	40.5
TYC RTC (Corsicana)	18	0.0	22.2	22.2
Halfway Houses	269	10.4	17.1	24.2
Ayres	35	8.6	22.9	34.3
Dallas	35	17.1	22.9	25.7
Beto	22	9.1	18.2	31.8
Middleton	39	7.7	12.8	20.5
Nueces	24	8.3	16.7	20.8
Turman	37	5.4	10.8	16.2
Schaeffer	46	15.2	21.7	26.1
Valley	31	9.7	9.7	19.4
Contract Care	427	9.8	19.7	25.8
Foster Care	60	13.3	20.0	21.7
Group Care	124	12.1	21.8	27.4
Residential Treatment Centers	86	11.6	20.9	26.7
Independent Living	8	--	12.5	25.0
Vocational	91	3.3	22.0	33.0
Drug Abuse-Paid Care	14	14.3	14.3	14.3
Other Contract Care	44	9.1	9.1	13.6
TYC Camps	95	33.7	45.3	50.5
Other	31	6.5	9.7	12.9
TOTAL	2534	19.1	31.8	38.0

Source: TYC, 1988b, p. 4.

References

Austin, David, and Ida Michie. 1989. Community Resource Intervention Notebook. Austin, Tex.: Hogg Foundation for Mental Health. (Draft Copy.)

Cannedy, Jimmy Lowell. 1989. Internal Auditor, Texas Youth Commission, Austin, Tex. Telephone interview, November 11.

Cannedy, Jimmy Lowell. 1988. "A Strategic Plan for the Texas Youth Commission." Professional report, The Graduate School of Business Administration, The University of Texas at Austin.

Fuchs, Gary. 1989. Executive Assistant, Texas Youth Commission, Austin, Tex. Interview, December 7.

Greenwood, Peter W., and Franklin E. Zimring. 1985. One More Chance: The Pursuit of Promising Intervention Strategies for Chronic Juvenile Offenders. Santa Monica, Calif.: Rand Corporation.

"Health Status of Detained and Incarcerated Youths." 1990. Journal of the American Medical Association, vol. 263, no. 7.

Keir, Scott S. 1989. Hogg Foundation. Memorandum to all participants in the August 1, 1989, meeting of the Severely Emotionally Disturbed Child and Adolescent Task Force with "Key Stakeholders" in children's mental health.

Loughran, Edward J. n.d. "Juvenile Corrections: The Massachusetts Experience." In Reinvesting Youth Corrections Resources: A Tale of Three States. Minneapolis, Minn.: Center for the Study of Youth Policy, Hubert H. Humphrey Institute of Public Affairs.

McKimmey, G. 1990. CASSP Director, Texas Department of Mental Health and Mental Retardation, Austin, Texas. Interview with Nicholas Hoover, October 12.

Mental Health Association in Texas. 1989. Do Kids Count? How Texas Serves Children and Adolescents with Severe Emotional Disturbance. Austin, Tex.

Orman, Elise. 1990. Chief of Counseling, Texas Youth Commission, Austin, Tex. Interview, February 13.

____________. 1989. Chief of Counseling, Texas Youth Commission, Austin, Tex. Interview, November 8.

Smith, Murray. 1990. Parole Officer, Texas Youth Commission, Austin, Tex. Interview, February 8.

Streit, Samuel M. 1988. "Juvenile Justice Reform in Florida--Testimony to the Tennessee Legislature," February 5, 1988. In Youth Correction Reform: The Maryland and Florida Experience. Ann Arbor, Mich.: Center for the Study of Youth Policy, School of Social Work, The University of Michigan.

Sunset Advisory Commission. 1987. Recommendations to the Governor of Texas and Members of the Seventieth Legislature. Austin, Tex.

____________. 1986. Texas Youth Commission. Austin, Tex. (Staff Report.)

Taylor, Don. 1989. Accreditation Manager, Child Care Division, Texas Youth Commission, Austin, Tex. Phone interview, November 7.

Tex. S.B. 222. 1989. Text of Conference Committee Report and Governor's Veto Proclamation, Supplement to Senate Journal, 71st Leg., Reg. Sess.

Texas Youth Commission (TYC). 1990. *Children's Interagency Planning Process*. Austin, Tex. (Questionnaire.)

————. 1989a. *Board Member Orientation Manual*. Austin, Tex. (Manual.)

————. 1989b. *Child Care*. Austin, Tex. (Pamphlet.)

————. 1989c. *Operational Overview*. Austin, Tex. (Brochure.)

————. 1989d. *Semi-Annual Evaluation Report*, *Report Period Second Half/FY 1989*. Austin, Tex.

————. 1989e. *Trends in Juvenile Service*. Austin, Tex. (Brochure.)

————. 1989f. *Strategic Plan*. Austin, Tex. (Brochure, Draft Copy.)

————. 1988a. *Emotionally Disturbed Youth in TYC*. Austin, Tex.

————. 1988b. *Recidivism Rates: Arrest, Conviction and Reincarceration*. Austin, Tex.

————. 1988c. *Semi-Annual Evaluation Report, Report Period Second Half/FY 1988*. Austin, Tex.

————. October 1988. *Request for Legislative Appropriations for Fiscal Year 1990 and 1991*. Submitted to the Governor's Budget and Planning Office and Legislative Budget Office. Austin, Tex.

———— and Texas Department of Mental Health and Mental Retardation (TYC/TDMHMR). n.d. "Memorandum of Understanding." Pursuant to Section 37 of S.B. 33, 70th Legislature. Austin, Texas.

Texas Youth Council. 1957. *Laws Relating to Children and Youth Administered by the Texas Youth Council*. Austin, Tex.

Van Vleet, Russell, Andrew Rutherford, and Ira M. Schwartz, n.d. "Reinvesting Youth Corrections Resources in Utah." In *Reinvesting Youth Corrections Resources: A Tale of Three States*. Minneapolis, Minn.: Center for the Study of Youth Policy, Hubert H. Humphrey Institute of Public Affairs.

Chapter 7. Tapping New Funds through Existing Infrastructure

When one considers Texas state agencies which deal with severely emotionally disturbed youth, TDMHMR, TDHS, the juvenile justice system, and TEA immediately come to mind. However, in the course of examining the many state agencies that interact with, or in some way affect, SED youth, possible new sources of funding for new and existing SED youth programs and services can be identified. Three established state agencies and one state council interact in various ways with youth who could be identified as SED: the Texas Commission on Alcohol and Drug Abuse, the Job Training Partnership Act of the Texas Department of Commerce, the Texas Rehabilitation Commission, and the Interagency Council on Early Childhood Intervention.

These four entities are relatively well-funded. They all receive federal as well as state and some local financial assistance. And all four entities serve what appear to be SED youth, albeit that their services are neither specifically directed toward nor focused on SED youth as such. Many of the clients served could be described, diagnosed, or otherwise attributed as having severe emotional problems. In researching the agencies, it was revealed that all had an apparent dichotomy between those they were mandated to serve and those they actually served. TCADA claims to treat substance-abusing youth, not SED youth; TRC claims to treat handicapped youth, not SED youth; JTPA claims to serve disadvantaged youth, not SED youth. Yet many of the clients in these programs display numerous and obvious characteristics of emotional disturbance. In fact, many of the indicators for youth at risk of substance abuse or failure in the work force as described by TCADA and JTPA are exactly the same indicators for youth who are considered SED.

These four state entities receive a sizeable amount of federal and state money. Although none at present offer specific and direct services to identifiable SED youth in their programs, the infrastructure exists by which to access additional funds. When this is combined with the identified but as yet unrecognized clientele already being served, there exists a capacity for meeting some of the needs of SED youth in Texas.

TEXAS COMMISSION ON ALCOHOL AND DRUG ABUSE

Many Texas youth have been adversely affected by the abuse of alcohol and other drugs. Recent studies by the Texas Commission on Alcohol and Drug Abuse (TCADA) indicate that youth are at greater risk of using, misusing, or abusing alcohol and other drugs than at any other time in our history. A study of secondary school students by TCADA and a report by the Joint Special Interim Committee on High School Dropouts demonstrated that 48 percent of Texas youth are considered to be "at risk" for substance abuse. The committee found that prevention strategies were crucial to addressing the long-term objective of keeping students from becoming at risk of dropping out by identifying them early in their elementary school careers as well as by better meeting their needs in those early grades (TCADA, July 1989, pp. 6-7). These findings correlate significantly with those for severely emotionally disturbed youth in that both groups share many of the same factors for becoming at risk of dropping out or abusing substances.

TCADA is the agency designated by the Texas Legislature to lead the state's efforts in substance abuse prevention. Legislation enacted states that TCADA is to "prevent broken homes and the loss of lives" (TCADA, 1988a, p. 5) and is to cooperate with all interested and affected federal, state, and local agencies and is to develop and coordinate prevention, intervention, treatment, and rehabilitation programs. TCADA is to expand drug, inhalant, and alcohol abuse services for children when funds are available because of the long-term benefits of these services to the state. It is the policy of the state that "a chemically dependent person shall be offered a continuum of services that will enable the person to lead a normal life as a productive member of society" (TCADA, 1988b, p. 5).

TCADA's mandate is to coordinate alcohol and drug abuse services of state and local agencies through the development of prevention, intervention, treatment and rehabilitation programs. TCADA's enabling legislation gives the commission a twofold responsibility. TCADA is a regulatory agency which licenses all facilities which provide alcohol and drug abuse treatment within the state, including private, public (except for other agencies), and nonprofit organizations. TCADA is a broker of funds to community-based providers of substance abuse services. TCADA also keeps statistics on alcohol and drug abuse and provides public awareness information using these data.

The Texas Commission on Alcoholism was established in 1953 as a small group that could begin to look into the negative effects of alcoholism on Texas society. It was not funded until 1957 when a small amount of state money was appropriated for a counselor at the Austin State Hospital. In 1959, more money was allotted for two counselors at the state hospital and one at the state prison. Texas' first drug abuse program was established in 1971 and became part of the Texas Department of Community Affairs. Sunset legislation in 1986 combined the Texas Commission on Alcoholism and the Drug Abuse Program into TCADA.

TCADA uses federal, state, and local funds for the development of comprehensive alcohol and drug abuse services at the community level. These programs are designed to reach youth and adults across the state. The goals of these programs are to

1. create a continuum-of-care system which uses a prevention and risk reduction approach, and which comprehensively addresses the treatment and rehabilitation needs of clients who are not able to pay for services;

2. increase the cooperation and formal linkages between substance abuse services and local agencies, community organizations, private service organizations, and the media;

3. improve the state-of-the-art substance abuse services by allowing organizations to select a wide variety of strategies with which they can develop their own models in response to the needs of their target populations and to fit the scope of their abilities and resources;

4. provide an opportunity for development and integration of a wide range of substance abuse services in traditional and nontraditional settings. (TCADA, September 1989a, p. 1)

Rather than attempting to create new service delivery systems, the focus is on enhancing and linking the systems already in place. To accomplish this, TCADA encourages the formation of partnerships with communities, organizations, and institutions. Emphasis is placed on evaluation, accountability, resource sharing and management, and integration and linkage of services to meet client needs in the most cost-effective manner. Strategies include integrating services into settings such as public health clinics, correctional facilities, youth homes, family violence shelters, and housing projects, which have not traditionally been utilized for the provision of substance abuse services.

TCADA has proposed a "systems approach" for developing comprehensive alcohol and drug abuse services for youth across the state. The intent is to create a continuum-of-care system for youth using prevention and risk-reduction models. Prevention and risk reduction involves multiple strategies, implemented at the community level, and involving a large number of citizens and groups within the community. Furthermore, the "systems approach" addresses the needs of those individuals who have already developed a dependency on alcohol and drugs (TCADA, July 1989).

Services funded by TCADA fall into two general service categories: prevention/intervention and treatment. The programs within these service categories are administered and operated by providers at the community level and are funded by grants awarded through TCADA. Several different programs serving youth exist in each category, and each award recipient must provide certain services as discussed below.

Service Category: Prevention and Intervention

Primary Prevention. The purpose of this program is to provide services which prevent the use of alcohol and drugs, both illegal and prescription, as well as to promote community attitudes and policies that prevent substance abuse. The target populations for these services are youth, parents, and families; business, management, and labor; and professionals in health and human services, law enforcement, criminal justice, city/county governments, and religious and educational institutions. Services provided for youth revolve around public awareness and media campaigns, using brief, high-impact, and culturally appropriate dissemination vehicles including, billboards, posters, bumper stickers, videos, radio and television news programming, special subject documentaries, print journalism, marches, state and local resolutions, and many others; education, dispensing information on alcohol and drug abuse and its effects and effective methods of prevention; and parent training, offering skill-building workshops to parents to help develop or enhance parenting skills in order to reduce the number of future at-risk youth (TCADA, July 1989).

Early Intervention. These model programs are aimed at youth in the early stages, or those at risk, of alcohol and drug abuse or addiction. The primary target population includes youth whose behaviors, environment, or circumstances place them at risk for substance abuse. At-risk youth, as defined by the Drug-Free Schools and Communities Act of 1986, means individuals under the age of 21, who are at high risk of becoming or who have been drug or alcohol abusers, and who are experiencing problems such as the following:

1. family substance abuse/dependency
2. sexual, physical, or psychological abuse and/or neglect
3. personal or family crisis
4. pregnancy or teen parenthood
5. difficulty in establishing and maintaining relationships
6. rejection by school peers or gang involvement
7. prolonged poor academic performance
8. placement in an alternative school or suspension
9. runaway incidents
10. abandonment or homelessness
11. battered or battering parents
12. eating disorders
13. disabling injuries
14. juvenile or criminal justice involvement
15. suicidal ideations or tendencies
16. poverty
17. latch key situations
18. withdrawal from normal school activities or peers
19. involvement in destructive or disruptive behavior
20. school disciplinary problems
21. increased absences and truancy
22. dropping out of school
23. numerous foster home placements.

These are many of the same warning signs evident in youth with severe emotional disturbances. Although TCADA does not specifically recognize or treat severely emotionally disturbed youth in its programs, the close correlation between indicators for substance abuse and emotional disturbance serves as evidence that many SED youth are within the system of care established by TCADA.

Early intervention programs are community-based and have as their objective the goal to prevent progression into the chronic stages of dependency. These programs provide identification, screening and assessment, and referral services to abusers and family members as well as education and training to indirect service providers (such as criminal justice personnel, clergy, social workers, doctors, and nurses) on methods for intervention with and referral of the substance-abusing person. Other services for youth may include, but are not limited to, crisis counseling, advocacy, support groups, alcohol and drug education, life-skills training, and referral for unmet needs. These services are offered by providers who have contracted with TCADA located in schools, housing projects, places of employment (such as fast-food restaurants with high numbers of young employees), and a wide variety of community-based youth service organizations. The intervention program may also provide family education classes designed for family members of substance abusers in order to help the family understand the concept of addiction as a disease, giving them strategies for coping with the addict, and offering them resources so that they may pursue additional help (TCADA, July 1989).

Intensive Intervention. These model programs are designed to intervene in the lives of youth whose at-risk behaviors, circumstances, or environments have resulted in substance abuse, but not dependency or addiction, and whose behavior is not severe enough to require substance abuse treatment, and who are not being adequately addressed by other social service institutions. These community-based programs provide intensive services with the intent to halt the abuse of substances, promote healthy behaviors and lifestyle choices, and prevent relapse of those who have successfully completed treatment. While heavily at-risk youth are the primary target population, there is also a secondary target population consisting of parents, siblings, peers, and the future children of pregnant youth, who can also be the recipient of services. Intensive intervention programs include the following four services: intervention counseling, substance abuse alternatives, substance abuse education, and crisis intervention and referral (TCADA, July 1989).

Intervention Counseling Services are designed to provide assistance and support to youth during critical periods of their lives in order prevent substance abuse. Specific strategies may include individual, family, group, and peer counseling; and advocacy for clients' needs with family, schools, the juvenile justice system, community agencies, and current employers.

Substance Abuse Alternatives Services provide structured, supervised group activities designed to offer positive alternatives to substance abuse through meaningful cultural and community activities and to provide opportunities for constructive peer pressure. Alternative programs involve activities in which participants can develop an increased level of confidence, self-discipline, self-reliance, and optimistic feelings about themselves and their environment.

Substance Abuse Education Services are designed to promote a greater understanding of substance abuse and its concomitant problems. It also assists individuals and groups in developing effective peer and social resistance skills. Activities often include curriculum development, training, and other structured learning experiences that promote the development of skills in decision-making, coping with stress, interpersonal and cross-cultural communication, and self-motivation.

Crisis Intervention/Referral Services are designed to remediate a situation which may result in a crisis if it does not receive immediate attention. Situations which require some degree of intervention may or may not involve substance abuse issues. These services may involve face-to-face counselor interviews or telephone contact, crisis or short-term counseling, and the provision of information and assistance to youth in gaining access to appropriate community service resources. In FY 1990, a total of $5,595,569 was awarded to 54 providers of Primary Intervention, Early Intervention, and Intensive Intervention services throughout the state (Appendix 7.1 and 7.2).

Student Assistance Program. This model program is aimed toward at-risk students below the age of 20 who exhibit any of the identifiers for tendency toward substance abuse. The Student Assistance Program is school-based by design, but may be operated either by the school district or by an outside entity in cooperation with the school district. The objective of this program is to help students who have problems that interfere with their ability to function at school. The program serves to identify, assess, and motivate for treatment students whose academic performance is impaired by substance abuse, chemical dependency, emotional problems, mental illness, and other personal problems. This program relies on either self-referrals or referrals by teachers and other school staff. Students are then channeled to an appropriate evaluation and referral resource which is responsible for identifying the nature of the problem. The referral by the school staff person is based on documented, prolonged, unacceptable performance in areas such as absenteeism, incidents of misbehavior, poor and erratic relations with teachers or students, declining grades or quality of work, and other performance indicators or possible substance abuse behaviors. The Student Assistance Program also helps the student and family select appropriate community resources for treatment and rehabilitation and follows up to ensure that quality care is provided (TCADA, July 1989, p. 30). In FY 1990, a total of 18 recipients were awarded $1,767,256 to provide Student Assistance Programs (Appendix 7.3).

Pilot Intervention Services for High-Risk Youth. These model programs are a specialized pilot intervention project whose services are aimed at youth 18 years of age and younger who are not in school and are at risk of substance abuse. These services are provided in a community-based setting, and their objectives are to eliminate the incidence of substance abuse among this group, assist them in basic educational skills, provide vocational training, and provide family members with skills and training essential to the participant's success. All services address the cultural and ethnic values, customs, and practices of those being served. Specific strategies fall into one of two service components: the Personal Skill Development Program and the Family Training Program.

The Personal Skill Development Program is designed to assist, train, and provide employment for substance-abusing youth between the ages of 16 and 18 who are not in school. Mechanisms include drug education, basic educational achievement, General Equivalency Diploma (GED) preparation, and pre-employment and job skills training.

The Family Training Program is designed to involve, train, and assist family members, siblings (ages 12 to 15), and parents or legal guardians of youth enrolled in the Personal Skills Development Program with the necessary skills to provide support, proper role modeling, and intensive participation as a family unit in the overall service programming of the youth (TCADA, July 1989, p. 31). In FY 1990, 10 providers were given $610,375 for pilot primary prevention services for high-risk youth (Appendix 7.4).

Peer Assistance and Leadership Program (PAL). These model programs are designed to train older students to provide assistance and guidance to younger students and promote positive personal, social, and academic adjustments. The PAL program works with school districts and regional education service centers to develop sustaining peer-helping programs. Once the school district has committed to the program concept and selected an adult PAL sponsor, students and sponsors are trained to provide helping services that include individual and group peer counseling, peer tutoring, outreach to new or troubled students, and referral to other service agencies within the community. Services are typically provided during the regular school day, although PAL students frequently initiate and maintain contacts with younger students outside of school hours. Many program-related events are scheduled during evenings or on weekends. Most PAL programs are scheduled as a regular class, with many schools offering academic credit. Efforts have been made to secure Texas Education Agency academic credit on a statewide basis for PAL programs (TCADA, July 1989, p. 32).

Children of Substance Abusers. These model programs are intended to help youth under the age of 18 who have substance abuse in their families or are considered to be at risk for developing substance abuse problems due their behaviors or environment. The program can be either school- or community-based and seeks to reduce the risk of substance abuse in later years by providing highly at-risk children with information, education, skill building, and referral services in a support-group setting. The program serves to identify, contact, and enroll children who have a substance-abusing family history or who may be experiencing school-related problems. The program relies on referrals from family, youth human services and juvenile justice agencies, drug and alcohol treatment programs, school personnel, and health services agencies. The program provides services to children based on a written curriculum that focuses on helping them develop skills for coping in a substance-abusing environment, thereby reducing the risk of developing substance abuse problems in later life. The program also helps the youth and family select appropriate community resources that the program cannot provide (TCADA, July 1989, p. 26). In FY 1990, $2,010,030 was allotted to 21 providers for the provision of services under the Children of Substance Abusers programs (Appendix 7.5).

Overall, the number of youth in community- and school-based programs receiving substance abuse prevention and intervention services in FY 1989 was 1,027,790. This was a dramatic increase from the 362,600 youth who received these services in FY 1988, due largely to the tremendous increase in federal funds made available to TCADA. There were 547 schools involved in providing substance abuse prevention services in FY 1989. In summary, TCADA awarded 103 providers a total of $9,983,230 to offer prevention and intervention services to Texas youth in FY 1990.*

Service Category: Treatment and Rehabilitation

Treatment and rehabilitation services are the final category of programs funded by TCADA and must meet its Chemical Dependency Treatment Facility Licensure Standards. Treatment programs include detoxification, residential programs (where a person can live from 30 days to six months) and outpatient programs. Services for youth are delivered primarily through two different residential programs: Adolescent Substance Abuse Treatment and Rehabilitation and Adolescent Inhalant Abuse Treatment and Rehabilitation. Both of these programs serve youth who are 13 through 17 years of age whose primary condition is the addiction to, dependency upon, or chronic use of drugs, alcohol, inhalants, or any combination of each. Among these are several recognized subgroups which may require special treatment and rehabilitation programming, including

1. youth involved in the criminal justice system,
2. youth with multiple prior substance abuse treatment episodes,
3. youth with no prior substance abuse treatment episodes,

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* The actual amount of funds awarded to youth services is slightly overstated. Some of the local programs included in the calculation also provide adult services which were not broken out from the total award.

4. youth whose primary choice of drugs is inhalants or "crack,"
5. youth who demonstrate the need for specialized services and treatment modalities,
6. youth who are pregnant and have medical and infant care needs, and
7. youth who are handicapped and have special transportation, communication, and recreational needs. (TCADA, July 1989, p. 23)

The purpose of these residential programs is to provide an intensively supervised setting for treatment with a phased system which provides for transition from one phase to another, based upon the client's readiness and progress, in a progression toward a less restricted environment or independence. Medically supervised detoxification services may or may not be required to treat the client. Local providers have the option of providing detox services themselves or purchasing those services from other providers, such as general hospitals. Residential treatment services are intended to assist the client in identifying the relationship between substance abuse and its subsequent pitfalls and to expose the client to a wide range of therapeutic, experiential, educational, self-exploration, and supportive activities. Providers of these programs must provide a minimum of two hours per client per week of therapeutic counseling services and one hour per client per week of substance abuse therapy (TCADA, 1988b, p. 65). Both outpatient and residential substance abuse treatment and rehabilitation settings provide education, counseling, and therapy for the participants and their families, intensive life skills training, parenting education for youth and their families, academic education, GED preparation, vocational education and training, and constructive "leveling" systems which emphasize individual and group responsibility (TCADA, July 1989, p. 23).

There are 26 residential and outpatient youth treatment and rehabilitation providers which were awarded $8,111,722 in funds for FY 1990 (Appendix 7.6) (TCADA, September, 1989b). There were 2,433 youths who received these services in FY 1989, with 16,060 residential bed days and 20,000 hours of outpatient counseling (TCADA, August, 1989).

Residential and outpatient treatment and rehabilitation programs are very expensive due to strict operational and staffing requirements. (Goodman, Interview, November 9, 1989). Indeed, funding for substance abuse programs has been given special consideration by both federal and state legislatures over the past few years as the drug problem has leapt into public consciousness. Due to changes in the Alcohol Drug Abuse and Mental Health block grant for FY 1988, TCADA received a 117 percent increase in federal funding, followed by an additional 18 percent increase in FY 1989 and an estimated 35 percent increase for FY 1990. The federal portion of the TCADA budget was $33,452,440 for FY 1990 and $33,456,180 for FY 1991 (Appendix 7.7) (TCADA, October 1989). The Texas Legislature has also increased the amount of general revenue funds for TCADA by nearly 230 percent, from $4,567,350 in FY 1989 to $15,053,953 in FY 1990 (Tex. S.B. 222, 1989). When combined with the increase in federal funds, the estimated total budget for FY 1990 is $48,732,474 and for FY 1991 is $50,335,604 (TCADA, October 1989).

Approximately 30 percent of the funds allotted to TCADA for FY 1990 is drawn from the Texas general revenue fund, while 68 percent is derived partly from the federal Alcohol, Drug Abuse, and Mental Health Block Grant and the federal Drug-Free Schools and Communities Act of 1987. However, both the state and federal dollars are earmarked. Of the amounts in FY 1990 appropriated for prevention and intervention services, $4.52 million is targeted specifically for the expansion of these services for youth (Appendix 7.7). Of the total amount appropriated for treatment services, $6.29 million has been earmarked for youth (Tex. S.B. 222, 1989).

Interagency Coordination

TCADA deals with other state agencies on a regular basis, having developed numerous contracts and memoranda of understanding (MOU). Currently in the development stages, the Texas Youth Commission (TYC) has contracted with TCADA in the amount of $726,000 to replicate the Gainesville State School Chemical Dependency Treatment Program at the Giddings State School. This will add two related programs at the facility for youth at other stages of need or after completion of the training school program. The program also provides consultation and educational materials for the establishment of ongoing group counseling at each of the four TYC institutions which do not have a chemical dependency treatment program (Brownwood, Crockett, Corsicana, and West Texas Children's Home). TCADA is closely monitoring the implementation and progress of each substance abuse program component.

TCADA has awarded $1,349,375 to be used for clients of the Texas Juvenile Probation Commission, Texas Adult Probation Commission, and the Board of Pardons and Paroles (TCADA, August 1988a, p. 12). These funds go directly to local programs selected by these state agencies, rather than being awarded to the state agencies. The following state agencies received funds from TCADA for FY 1988: TYC ($236,709), TDMHMR ($1,203,565), TRC ($50,000), TDH ($41,843), Texas Commission for the Deaf ($60,000), and TDC ($500,000) (TCADA, August 1988a, p. 12).

There are more than 15 state agencies whose clientele include people who have a problem with alcohol and drug abuse. The principal agencies can be divided generally into four categories: social services (TRC), health services (TDH and TDMHMR), education (TEA), and criminal justice (TYC, TJPC, and TDCJ). Each of the agencies in these different areas provides services in one way or another to chemically dependent people, although none were established by law to deal with the problems of alcohol and drug abuse. TCADA is focused on serving the needs of citizens with alcohol and drug abuse problems, including those who may also be clients of these other agencies. Youth with severe emotional disturbances are undoubtedly coming into contact with these agencies and with TCADA, but no multilateral agreement exists among these agencies and TCADA to provide services explicitly for SED youth.

Current Issues of Concern

Federal law presents significant impediments to free sharing of information with other state agencies about chemical dependency clients. The impediment to exchange of client information duplicates effort and increases costs of providing services to all involved agencies. The regulations of the U.S. Department of Health and Human Services supersede conflicting state law and require the special consent of a client before any patient-identifying information can be revealed by the program or disclosed by any entity lawfully receiving such information from a program under the regulations. In the absence of valid written consent, a highly individualized court order and subpoena is required under these regulations before any patient-identifying information can be disclosed. They apply to all federally tax-exempt chemical dependency programs, including some prevention and intervention programs, and any other programs which receive direct or indirect federal assistance. In addition to federal regulations, there are a variety of state laws which limit disclosures about individual chemical dependency clients (TCADA, August 1988b, p. 11).

Other federal restrictions are found in the Privacy Act of 1974, 42 USC 552a, and the Medicare and Medicaid acts and their regulations. In most cases, consent of the client or express statutory authority will allow disclosures under state and other federal law, but the U.S. Department of Health and Human Services regulations are much more restrictive than would allow for efficient tracking of clients.

Recently, TCADA has been involved with the Texas Department of Human Services (TDHS) in searching for joint initiatives that could address the issue of a growing incidence of substance abuse. One initiative is for TDHS to provide treatment services for chemically dependent Medicaid recipients under 21 years of age through the Early and Periodic Screening, Diagnosis, and Treatment (EPSDT) Program. TCADA has proposed that chemical dependency treatment services for Medicaid-eligible youth could be provided through a mix of residential treatment and outpatient services. This proposal is discussed in greater detail in Chapter 14.

Data Sources

TCADA has a wealth of accessible data on magnetic tape. There are seven databases provided by and in conjunction with other agencies, four surveys currently in progress as well as data from previous surveys, and a client database. Possible extractions related to youth include clients in intensive treatment and counseling, as well as results from the statewide survey of schools which is conducted on a biennial basis. There is no information directly available dealing explicitly with children classifiable as severely emotionally disturbed.

JOB TRAINING PARTNERSHIP ACT

The Job Training Partnership Act (JTPA) was established in an effort to help disadvantaged individuals become productive members of the work force. Youth are specifically recognized in the legislation as the beneficiaries of a portion of JTPA services, focusing on the unskilled and economically disadvantaged. Severely emotionally disturbed youth, or youth with any mental disorder generally, are not a population specifically focused upon by JTPA legislation. However, much leeway exists at the local level in determining participant eligibility criteria. In fact, several JTPA programs operated at the local level in Texas serve youth categorized as "at risk" or as mentally or physically handicapped. In this light, the niche exists for providing services to severely emotionally disturbed youth.

In 1982, the federal government enacted the Job Training Partnership Act (PL 97-300), which followed 20 years of federal involvement in job training programs. Under JTPA, control of employment and training programs shifted from the federal level to the state and local levels with the involvement of the private sector. The intent of JTPA legislation is to establish programs to prepare economically disadvantaged youth, unskilled adults, individuals who are unemployed because of business closings or layoffs, and others who face serious barriers to employment (TDOC, 1988, p. 4). This is accomplished by providing these individuals with job training and other services that will lead to productive employment. These programs provide job searches, job counseling, pre-employment and job skills training, literacy services, job development, vocational education, and other support services related to assisting youths and adults obtain and maintain employment. The intent of the legislation is additionally furthered by providing employer incentives through the allocation of monies to train potential employees (TDOC, August 1989, p. 1).

Legislative and Organizational Context

When JTPA was enacted in 1982, it redirected the basic policy framework for the nation's unemployment and training system. Prior to this, federal involvement in job training programs began as a response to workers who were displaced by automation. Within a year, however, the focus shifted to the disadvantaged (TDOC, n.d., p. 9). The act decentralized programs by granting funds to state governors to be administered at the local level. The act authorizes the formation of joint partnerships between the private sector and local elected officials. The thrust of these decentralized programs was placed on classroom training, on-the-job training, summer youth programs, and special programs for older and dislocated workers. This legislation does not permit public service employment and requires a system of accountability.

The JTPA is divided into five sections. Title I establishes a service delivery area (SDA) system and outlines the powers and responsibilities of the governor, provides for program performance standards, and identifies other fiscal and administrative requirements for federal compliance. Title II describes allowable training, services, allocations, and participant eligibility for adult and youth programs. Title III describes allocations, a matching fund requirement, authorized activities, and other program operation requisites for the Employment and Training Assistance for Dislocated Workers Program. For the purposes of the act, dislocated workers are those who face unemployment due to a layoff or plant closing and are unlikely to return to their previous industry or occupation. Title IV addresses the federally administered programs for Native Americans, migrant and seasonal farm workers, Job Corps, and military veterans. Title V amends the Wagner-Peyser Act and Part C of Title IV of the Social Security Act in addition to directing enforcement of the Selective Service Act for participants in JTPA (TDOC, 1988, p. 4).

Funds are allocated by formula to SDAs or released through a competitive bid process to entities offering state-supported special initiatives (Appendix 7.8). Three factors weigh equally in the allocation of money to SDAs under Title IIA. First, the number of unemployed in the SDA, then the number of economically disadvantaged in the SDA, and last the excess number of unemployed (TDOC, n.d., p. 18).

Title II of the JTPA is the touchstone for the provision of youth services. This title is divided into two types of services-required and their funding. Part A sets requirements for local year-round training services for disadvantaged and unskilled youth and adults. Part B outlines the design for summer youth programs intended to help economically disadvantaged youth develop skills that will enhance their future employability. Youth with physical and mental handicaps are also receiving services under Title IIA. Although severely emotionally disturbed youth are not specifically identified as receiving services under either Part A or Part B, it is possible that these youth may be participants in various programs.

Title IIA

Part A funds are divided into two sections: 78 percent of the funds allocated annually by formula to SDAs and 22 percent which remain under direct state control and are earmarked for specific uses and unique target populations (Appendix 7.9). The 22 percent funds are broken out into four distinct programs: 8 percent (Section 123) for Education and Coordination, 3 percent for Older Workers, 6 percent for Performance Incentives/Technical Assistance and Training, and 5 percent for state-level administration costs. The 78 percent fund is the largest single block of JTPA money available to the state. Part B funds pass from the federal government through the state and then to the local SDAs at 100 percent by formula. The TDOC allocates funds directly to the SDA for program services to adult and youth participants who meet eligibility requirements (TDOC, 1988, p. 8).

The population that is served under Title IIA is restricted by the act as well as by state policy. At least 40 percent of the funds granted to SDAs must be spent on youth, with adjustments possible for variations in local youth populations, and at least 90 percent of the participants must be economically disadvantaged. In 1987, over $41.6 million was stipulated for youth programs (TDOC, 1988, p. 7). Specific segments of the population have been identified to target the limited resources and to provide equity in the delivery of services. Service priorities have been established for unemployed females, blacks, and Hispanics living below the poverty level, Aid to Families with Dependent Children (AFDC) and Worker Incentive (WIN) registrants, economically disadvantaged youth, and dropouts. In FY 1987, Title IIA served 8,351 youth between the ages of 14 and 17 and 13,477 youth between the ages of 18 and 21, accounting for 46 percent of all Title IIA recipients (TDOC, 1988, p. 8). As of December 31, 1989, there were a total of 20,098 youth participants under Title IIA. To varying degrees, each SDA reported serving youth with physical or mental handicaps, totaling 1,737 statewide (TDOC, January 1990, pp. 1-68). There is no breakdown available, however, for the number of youth with mental as opposed to physical handicaps, nor are there any statistics which identify participants who may be severely emotionally disturbed.

JTPA has very stringent cost limitations on the use of funds, which apply not only to Title IIA funds but other JTPA programs as well. A minimum of 70 percent of the funds must be used for job training. A maximum of 15 percent of the funds may be used for administrative costs, and a maximum of 15 percent of the funds may be used for participant support services. Waivers to this 70/30 split are allowable if an SDA meets federally mandated criteria. The waiver authorizes the SDA to adjust the training cost limitation below 70 percent and increase the participant support limitation above 15 percent. This serves to provide more supportive services to those special groups which need help to stay in training. The 15 percent cap on administrative costs may not be exceeded under any circumstances (TDOC, n.d., pp. 41-42).

The type of services provided for youth under Title IIA can be exemplified by the Communities in Schools-San Antonio (CIS-SA) Program provided by the Alamo SDA in FY 1987. This program assisted students at risk of dropping out by providing social, educational, and literacy services to them and their families beyond what the school district was able to provide. This program generated additional funding of $21,000 from the Texas Department of Criminal Justice, private-sector matching funds in the amount of $8,000, and private-sector in-kind contributions of $13,500 (TDOC, 1988, p. 33). CIS-SA tracked students who did drop out and recovered roughly 60 percent back into the school system. CIS-SA worked with officials of the Edgewood Independent School District, one of the poorest school districts in the state, in developing a realistic summer program for students who needed remedial education as well as compensated employment. The program is unique because of its public partnership agreements with state agencies such as the Texas Department of Human Services, Texas Employment Commission, Bexar County Juvenile Center, and the Metropolitan Health District. These agencies repositioned staff members to work with CIS staff in serving the target population of at-risk students and in intervening immediately with students and families. CIS involved the private sector through direct participation in planning and programming via a board of directors (TDOC, 1988, p. 33).

Section 123

Section 123 of Title IIA sets aside 8 percent of the Title IIA allocation for programs coordinated with state and local education agencies. Texas sends 80 percent of the funds directly to the SDAs for services to participants, while the remaining 20 percent is used for coordination, research, evaluation, and state-level administration. Section 123 resources focused on two statewide goals: (1) to improve the quality and level of services to at-risk youth (defined as young people, ages 16 through 21, who have experienced difficulty or encountered barriers in progressing through the natural system of education and employment), and (2) to improve the basic skills and job readiness of hard-to-serve adults. The governor's plan stresses that Section 123 funds should be used to build and enhance the capability to serve these two target groups through coordination of JTPA services with education.

The TDOC and the Texas Education Agency (TEA) agreed that the 80 percent funds allocated directly to the SDAs would be contracted with TEA-approved local education agencies to provide services to at-risk youth and hard-to-serve adults. The 20 percent funds are directed toward state-level interagency coordination to increase the capacity for joint planning of diverse services to these two populations. SDAs use their allocated 80 percent funds to design participant-serving projects and set local objectives, keeping the two statewide goals in mind. Twenty-five percent of enrollees can be educationally, as opposed to economically, disadvantaged. In 1987, Section 123 of Title IIA served 752 youth between the ages of 14 and 17 and 646 youth between the ages of 18 and 21, accounting for 61 percent of all Section 123 participants. Out of all 2,284 youth served by Section 123, 63 percent were female, 79 percent did not have a high school diploma, and 73 percent were minorities (TDOC, 1988, p. 9).

Interagency Initiatives

With most of the state's youth enrolled at one time or another in the general educational system, a significant effort has been placed on improving services to JTPA-eligible participants through closer coordination with TEA and the local school districts. As part of an interagency policy initiative, the state JTPA effort has centered on two TEA programs, the Public Education Information Management System (PEIMS) and the State Dropout Information Clearinghouse. Mandated to TEA, PEIMS includes identification and definition of dropouts and their referral and tracking at the local school district level. PEIMS is also responsible to TDOC for developing rural and urban models for tracking dropouts for recovery. The dropout clearinghouse creates a network for local service providers. In addition to being a repository for PEIMS data, the clearinghouse provides both information on statewide dropout prevention and recovery to local network groups as well as access by state staff to local program and policy information (TDOC, 1988, p. 10).

In FY 1988, eight program contractors were selected to operate special at-risk youth model programs under Section 123. These programs were designed to serve school dropouts and low-functioning, out-of-school youth. Of theses eight programs, four were continuing two-year projects from FY 1987. They include the ACcess Learning Center at Amarillo College, the Dallas Can! Academy, the Gulf Coast Trades Center, and the Permian Basin Regional Planning Commission. The four newly funded one-year projects include the Hidalgo-Starr Cooperative (McAllen ISD), Northeast Texas Community College, Paul Quinn College, and the Rural Capital Area Private Industry Council.

Title IIB

Title IIB programs, also known as Summer Youth Employment and Training Programs (SYETP), provide job training and employment opportunities for 14- through 21-year-olds during the summer. Summer programs are designed to help economically disadvantaged youth develop skills that will enhance their future employability. The goal of these programs is dropout prevention for at-risk youth who are still in school. During FY 1987, Texas received $43,439,896 from the U.S. Labor Department. In 1988, summer youth programs received $65,527,821 (Appendix 7.9). Under JTPA requirements, 100 percent of these Title IIB funds are allocated to the SDAs. In contrast to most other programs established by JTPA, the SYETP is also permitted to fund public service employment. In 1987, summer youth employment and training programs served 29,338 persons, with 34 percent between the ages of 14 and 15, 45 percent between the ages of 16 and 17, and the remainder up to age 21 (TDOC, 1988, p. 11).

A special Title IIB project for physically and mentally handicapped students, conducted during the summer of 1988, was funded by the South Texas PIC, the Texas Rehabilitation Commission, and Laredo ISD. Students were enrolled for eight weeks, during which time they earned high school credit while learning a specific vocational skill such as office services, general mechanical repair, food services, or construction trades (TDOC, 1988, p. 62).

Current Issues of Concern

Several items appear on JTPA's special projects agenda for the near future. The planning section is currently working with TEA on a plan to get more services for youth. Specifics are not available at this time. JTPA staff is also developing a technical assistance guide which will serve as a resource guide for SDAs and contractors to help make their provision of services more adequate and efficient. In terms of quality control, JTPA is formulating sanction policies for those SDAs that have performed below par for more than two years in a row. These sanctions are meant to be more supportive than punitive, combining corrective action plans with technical assistance for individual SDAs. JTPA is developing "planning training," also directed at SDAs, which emphasizes the fluid nature of work-force development. Economic conditions change every year, and SDAs are encouraged to become experienced at planning new strategies that address these changing local conditions (Dicks, Interview, November 7, 1989).

There is currently an MOU being developed between TEA, TDMHMR, and TRC in order to provide transitional services for SED youth. This is one area where JTPA could be extremely helpful. The 70th Texas Legislature enacted SCR 135 to encourage the above named agencies to improve coordination of their services to person with disabilities so that they may choose independent life styles. In September of 1990, the Texas Commission for the Blind, TDHS and the Texas Employment Commission joined the above named agencies in this effort. The purpose of this MOU is to enable students in special education make a smooth transition from school to working life (TEA, 1990, p. 2).

The MOU gives TEA the authorization for school districts to coordinate individual transition plans for students enrolled in special education who are at least 16 years of age, with other agencies. JTPA programs could be used in conjunction with these agencies inorder to offer a broader range of available transitional services.

Data Sources

Data are currently acquired and reported as mandated by performance measures established by the Secretary of Labor under Title IIA. During the 20 years of job training programs preceding JTPA, the federal government recognized the need to evaluate program performance, not process performance. The desired goal was to establish a system that measured the return of fund investments. Achieving this goal poses problematic questions, such as how to do so in an equitable manner, taking into consideration the unique state and local factors that influence program outcomes. Performance measures have evolved to help answer these questions. There are four measures for adults and three for youth. The youth measures include the following:

1. entered employment rate, which is the number of youth who entered employment at termination from the program as a percentage of the total number who terminated;

2. positive termination rate, which is the number of youth who had a positive termination as a percentage of the total number of youth terminated. A positive termination is defined as one of the following: (a).attainment of employment competencies established by the PIC; (b).completion of elementary, secondary, postsecondary school or the equivalent; (c).enrollment in apprenticeship or other training; or (d).enlistment in the armed forces;

3. cost per positive termination, which is the total expenditures for youth divided by the total number of youth who were positive terminations.

These performance measures are reported by each SDA and can be found in the annual report published by JTPA (TDOC, 1988, pp. 33-60).

JTPA has one MIS database which essentially stores all the information regarding agency operations--programs, activities, and services--from the state to the local levels. Statistical data on youth are accessible from this database. However, TDOC in Austin tends to focus on overall program operations and does not have information regarding each SDA readily available. To obtain a breakdown of youth data, such as that concerning number of participants and amount of funds spent on them, it is necessary to contact each individual SDA. Information from the MIS database is available for research purposes, upon written request, and is available on magnetic tape. Some fees may apply. There is no automated financial information on these tapes (Boyd, Interview, November 13, 1989).

TEXAS REHABILITATION COMMISSION

The Texas Rehabilitation Commission (TRC) is an independent state agency established in 1969. It is the state's principal authority on determination and rehabilitation of people with disabilities, except for persons who have visual and/or hearing impairments (TRC, October 1988, p. 2). Since 1973, prompted by changes in federal law, TRC has focused more services on people with severe disabilities, who now constitute 70 percent of all clients served. TRC defines *disability* as a physical or mental condition that substantially limits a person's activities or functioning. TRC does serve persons between the ages of 16 and 22, as well as adults. It is therefore important to examine the programs that TRC offers its clients in order to better understand where SED youth may be served in the future.

TRC is dedicated to providing people with disabilities opportunities to function effectively in society and in self-fulfilling ways. This mission serves as the impetus for strategically guiding programs and services for the foreseeable future. Of special interest to this research project, TRC places an emphasis on expanding the continuum of services it provides to Texans with disabilities. This continuum ranges from empowering persons to carry out independent activities of daily living, to transitional services which support persons in getting and keeping jobs, to vocational evaluation, training, and job placement (TRC, October 1988, pp. 2-3).

TRC does not see many youth, nor does it claim to provide explicit services for youth who might be regarded as severely emotionally disturbed. Moreover, TRC does not keep program statistics by client age; it is therefore impossible to provide program performance data which reflect solely youth participants (Fenoglio, Interview, January 29, 1990). It is not inconceivable that TRC may be serving clients at present who are SED, given the nature and number of disabilities seen by TRC staff each year. Considering its mission and goals, TRC may be in a position to serve SED youth in the future.

Description of Programs

TRC employs more than 2,000 manager, counselors, disability examiners, and support staff in 156 offices around the state. As the severity and complexity of disabilities as well as the nature of work have changed, TRC attempts to meet the needs of people with different and varying degrees of disability. The programs offered by TRC reveal a continuum of services designed to meet the changing needs of people with disabilities, from the onset of disability through the transitional phases of effectively coping with and mastering the disability to ongoing services for the more severely disabled (Figure 7.1). TRC spent an estimated $6,697 per successfully rehabilitated client in FY 1988. Of these funds, approximately 58 percent was used to purchase client services, 29 percent was used for counseling and placement, and 13 percent was used for administration (TRC, 1989, p. 6).

Figure 7.1. Continuum of Services Offered by the Texas Rehabilitation Commission

Rehabilitation Services--
--------Transitional Services--
------------------Independent Living Services--
------------------------------Disability Determination-------------------------------
--Advisory and Demonstration Programs---
---Administration Program

Outcomes range from competitive employment to more independent living within the community (TRC, n.d., p. 2). At one end of the continuum are services designed for people whose disabilities do not prevent them from finding continuous employment. At the other end of the service delivery continuum, services are provided to people whose disabilities are so severe that they have little or no work potential. Others find services appropriate for them in the middle of the continuum. Their disabilities may prevent them from competitive work, but will allow them to work in a noncompetitive, supported employment environment. The TRC service delivery system connects those with disabilities at one or more points along the continuum where they can take advantage of services which are appropriate to their needs and potential (TRC, 1989, pp. 3-4).

TRC administers eight major programs which provide a wide range of services to a wide variety of career and lifestyle options for its clients. Several of these programs, especially Extended Rehabilitation Services, Independent Living Services, and Deaf-Blind Multihandicapped Services, are particularly in demand by consumers as a result of a federal court ruling which mandated deinstitutionalization of people served by mental health/mental retardation services. In addition to the eight programs, TRC provides administrative support services to the Governor's Committee for Disabled Persons, the Texas Planning Council for Developmental Disabilities, and the Texas Advisory Board of Occupational Therapy (TRC, October 1988, pp. 3-4).

Rehabilitation Services: Vocational Rehabilitation. Since 1929, this state/federal cooperative program has provided services to help persons with mental and physical disabilities prepare for and find competitive employment. At this end of the continuum, services include on-the-job training; job search, resume writing, and interviewing skills training; arranging for the purchase of wheelchairs, as well as orthotics and other medical equipment; vocational counseling and guidance; interpreters for deaf persons; and arranging for transportation. Work adjustment classes in TRC field offices are also available to show prospective workers with disabilities how to get along with coworkers and how to function effectively with a disability in a structured work setting (TRC, 1989, p. 4). Youth find their way into vocational rehabilitation programs through referrals by the staff of local school districts.

In FY 1988, 58,426 adults were served by vocational rehabilitation programs throughout Texas, with 15,174 of them becoming successfully employed and 34,563 continuing to receive services (TRC, n.d., pp. 4, 24-30). A total of $84,449,900 was spent on vocational rehabilitation services to adults. The money for adult services, as well as those for youth, originates from the federal and state governments in a 74/26 percent split, respectively. In FY 1988, 11,818 youth were served by vocational rehabilitation services with an expenditure of $4,628,843 (TRC, 1989, p. 15). In FY 1988, nearly half--49 percent--of all vocational rehabilitation clients had some type of mental disability (Appendix 7.10).

Transitional Services: Extended Rehabilitation Services Program. Extended Rehabilitation programs serve persons whose disabilities are too severe to allow them either to hold jobs in the competitive work force or to benefit from vocational rehabilitation. Quite often, persons referred to the vocational rehabilitation program will find that they are not eligible for the competitive outcomes emphasized by that program; however, there may be a Transitional Services program, such as Extended Rehabilitation, that best fits their unique needs. This program provides supported work, and in some cases living quarters, to persons who can work but need continuous training and supervision. Twenty-eight programs across the state provide long-term services in structured work settings such as sheltered industries (TRC, n.d., p. 6).

The Extended Rehabilitation program was created by the 61st Legislature--passed as House Bill 287--and is supported entirely by state funds (TRC, October 1989, p. 5). Recognizing that institutional living does not provide the sense of self-worth that working in the community does, many persons served by Extended Rehabilitation Services are referred by the state schools, state hospitals, and nursing homes. Twenty-one cities across Texas are involved with this program: Amarillo, Austin, Edinburgh/Brownsville, Houston, Lubbock, Midland/Odessa, San Antonio, Bowie, Corpus Christi, Sulfur Springs, Waco, Ft. Worth, Alpine, Abilene, Missouri City, Weatherford, Tyler, Dallas, Wichita Falls, Laredo, and El Paso. Extended Rehabilitation Services gives people with severe disabilities a chance to be productive, and it gives parents and guardians a needed break from the demands of caring for persons with severe disabilities.

This program helps these persons gain employment--in both private nonprofit organizations and for-profit businesses--through industries, enclaves, and mobile crews as well as assisted and sheltered employment for those unable to work in less restrictive environments. Extended Rehabilitation counselors provide assistance in the form of transportation to and from work, medical assistance, wheelchairs, diagnostics and evaluation, and rehabilitation engineering techniques which help to maximize job abilities. Counselors also provide ongoing counseling and work closely with the staff of other human service agencies such as TEA, TDMHMR, TDHS, and the Social Security Administration to ensure coordinated delivery of services that best suit client needs (TRC, October 1989, p. 55).

The cost of a person with disabilities working daily in an Extended Rehabilitation program is about $11 per day for workshop expenses and an additional $10 per day if residential support is provided. In comparison, the cost of living in a state institution in 1987 was roughly $76 per day (TRC, October 1989, p. 5). In FY 1988, $3,820,633 in state money bought 1,071 adults Extended Rehabilitation services. An estimated $18,000 was spent on a total of 10 youth in the same year (TRC, 1989, p. 15).

Transitional Services: Interagency Transitional Services. This program builds a framework for disabled school-aged individuals by which they may move successfully from the public school to the work environment. A vital goal of this program is to establish a framework whereby TRC, local education agencies, and other appropriate state agencies can coordinate their respective service delivery system to achieve maximum efficiency in providing transitional services. Participants include students currently enrolled in school, persons who have dropped out of school or graduated without job skills and are reentering school, and eligible persons above 22 years of age. (TRC, n.d., p. 8). The intent of the program is to introduce students to the world of work through specially designed projects which are created through coordinated efforts between TRC, TDMHMR, TEA, and independent school districts. Demonstration models are currently operating in seven cities statewide: Dallas, Houston, Longview, Waco, Victoria, Conroe, and Austin.

The responsibility for identifying eligible students rests with the school districts, which then refer the individual to TRC. Primarily, these students have been in special education and vocational classes while in school. TRC counselors work with the students, parents, school staff, and local MHMR centers to place them in appropriate jobs. The students are able to achieve and maintain employment with assistance tailored to their unique needs. Out-of-school persons who may be eligible for and benefited by transitional services are identified by TRC and the aforementioned cooperating agencies (TRC, October 1989, p. 65).

Some significant policy developments in Transitional Services during FY 1989 have had and will continue to have an impact upon the program. First, TEA sunset legislation during the 71st Legislature included a mandate for individualized transition planning, beginning September 1990, for all students in special education who are 16 years old or older. Sunset legislation also mandated that a Memorandum of Understanding be written between TEA, TRC, TDMHMR, and other necessary agencies. This MOU is currently being drafted and is to be adopted by September 1990. Second, the Texas State Board of Education adopted new graduation requirements for students in special education, effective in September 1989, which emphasize the provision of employment and independent living skills for students as a prerequisite to graduation. Third, a TRC Commission Letter was published which addressed services for students with disabilities who are enrolled in special education. It set the tone for additional emphasis on transitional services in the TRC school program (TRC, 1990, n.p.).

The program had an increase of 29 percent in the number of clients served in FY 1989 compared with the previous year. For FY 1990, it is estimated that there will be 16,392 students with severe disabilities who need long-term support. It is believed that 18 percent of these disabled students will drop out of school (TRC, October 1989, p. 65). In FY 1988, $400,000 in state money was spent on a total of 148 students (TRC, 1989, p. 15). The same amount of money has been allotted for FY 1990.

Transitional Services: Supported Employment. This program began in 1987 with a federal grant totaling $7 million to be used over a five-year period and is authorized by Title VI, Part C, of the Vocational Rehabilitation Act. The Supported Employment program is intended to extend employment potential beyond the structure of the Extended Rehabilitation Services program. It is designed for adults and youth with disabilities too severe to benefit from traditional vocational rehabilitation services by providing work opportunities in the community with nondisabled persons through special support services (TRC, n.d., p. 9).

The program contracts with service providers in the community who pay for specially trained staff and provide individualized services. Program participants work alongside persons without disabilities in factories, retail stores, and various sectors of the service industry sector. They do this with the continuing assistance of an on-the-job coach (for participants with mental disabilities) and other support staff (for participants with physical disabilities). To be eligible, a person must

1. have a severe disability;

2. have never worked before, have worked intermittently, or had work interrupted due to the severity of a disability;

3. have the potential to engage in competitive employment if provided with the right support services;

4. not be eligible for traditional vocational rehabilitation services. (TRC, October 1989, p. 71)

Support services are tailored to fit the unique needs of each consumer. For example, a person who is moderately or severely mentally retarded would be provided assessment and planning services to determine the kinds of jobs of which that person is capable and in which that person is interested. Placement in a real job for real pay is the next step. A job coach is provided to ensure that critical job duties are learned. The coach may also work with a small group of persons with severe disabilities at a single business or with a work crew transported between job sites. Although the amount of individualized training at the job site will decrease over time, support is always available for as long as the consumer is employed (TRC, October 1989, p. 71).

After 60 days of "stabilized" work, the TRC counselor serving the consumer records this as a successful closure of the case. Federal funds are then terminated and funding for continued support is given by the service provider for as long as the consumer continues to work. In FY 1988, the federal government spent $2,366,377 to place 216 individuals--of which 77 were successfully closed. Out of these funds, $46,320 went to youth; 8 of the 77 closures were between the ages of 15 and 19 (TRC, 1989, p. 15).

Independent Living Services: Independent Living Program. Independent Living Services represents the far end of the continuum of services provided by TRC. These services enable persons with disabilities to live more independent and dignified lifestyles (TRC, October 1989, p. 85).

The Independent Living Program provides services which help adults and youth with severe disabilities to live as independently as possible. This is accomplished by two means: services of an Independent Living Center (IL Center) and comprehensive services for independent living. IL Centers offer a broad array of services such as peer counseling, information and referral, advocacy, independent living skills training, assistance with housing, transportation, personal care attendants, as well as social and recreational activities. Comprehensive services are located in the same areas of the state as IL Centers and complement, rather than duplicate, the services of an IL Center. Services encompass such things as sponsorship of medical rehabilitation (physical, occupational, and speech therapy), adaptive equipment, and nonvocational training (TRC, October 1989, p. 85).

FY 1989 concluded a period of rapid expansion for the Independent Living Program. During the past year, a new IL Center was started in Lubbock, and the Independent Living Services program was expanded to Ft. Worth, the Valley, and Lubbock. At the end of FY 1989, there were ten IL Centers in Texas, with an Independent Living Services project site associated with each: Amarillo, Lubbock, Ft. Worth, Dallas, El Paso, Crockett, Austin, Houston, San Antonio, and the Lower Rio Grande Valley. Although the 16 counties served by these ten programs represent only about 5 percent of the total area of the state, over half of the population of Texas lives in these counties, thereby maximizing the number of consumers for which these services are available (TRC, 1990, n.p.).

The number of consumers served by IL Centers has increased significantly between FYs 1987 and 1989, with totals of 2,100 and 2,755, respectively. The budget has also increased from $1,200,000 in 1987 to $2,400,000 in 1989. Comprehensive services have increased the number of consumers from 731 in 1987 to 1,294 in 1989, with an operating budget in FY 1989 of $1,800,000. Due to the increase in the number of project sites, however, the average amount of money available to each counselor has remained relatively constant (TRC, 1990, n.p.). In FY 1988, 337 out of approximately 2,700 consumers were youth, and an estimated total of $425,000 was spent on them (TRC, 1989, n.p.). These are the only figures on youth available.

Disability Determination Program. The Disability Determination Program does not provide direct services to persons with disabilities. The Disability Determination Division (DDD) makes assessments of disabilities based upon criteria established by the Social

Security Administration. Persons determined to be disabled will receive either Social Security Disability Insurance (SSDI) or Supplemental Security Income (SSI) benefits. If a person is ineligible for TRC services because of the severity of a disability, SSI benefits will enable that person to meet basic needs through both direct cash payments and other benefits (TRC, October 1989, p. 137). Mental disabilities can entitle a person for disability and medical benefits.

Advisory and Demonstration Programs. The Advisory and Demonstration Programs are empowered to provide new services to handicapped Texans through demonstration programs as well as to provide advocacy and oversight services. The Texas Planning Council for Developmental Disabilities exists to promote changes in federal and state laws, state agency policies and programs, and community attitudes that will enable people with developmental disabilities to achieve maximum independence, productivity, and integration. The Advisory Board of Occupational Therapy is designed to protect consumers by licensing occupational therapists and assistants. The Governor's Committee for Disabled Persons serves to increase employment opportunities by raising public awareness of the abilities and special needs of persons with disabilities. Finally, the Literacy and Communication Development Program for Deaf Adults is directed to raise the reading and writing abilities of participating deaf adults to fifth- or sixth-grade level and improve their use of alternative communication systems (TRC, October 1989, pp. 137-197).

Administration Program. As the hub of all TRC activities and services, the Administration Program provides the leadership management and oversight necessary to ensure that high-quality, timely client services are the emphasis of all employees of TRC. Planning, guidance, policies, and procedures vital to client services are developed within and executed by the Administration Program (TRC, October 1989, p. 197).

Data Sources

TRC maintains a large database with information on clients and operations. However, no program operation or performance data are available broken out by age; as such, no uniform, comprehensive, or detailed information can be pulled out with singular regard to youth. Access to the database is somewhat restricted, and it may be a lengthy process to apply for permission to access the data.

TEXAS EARLY CHILDHOOD INTERVENTION (ECI) PROGRAM

The Interagency Council on Early Childhood Intervention was developed in 1981 (Chapter 73 of the Human Resources Code) to provide intervention services to children ages 0-3 who have a developmental delay or are at risk of developing a delay. The five-person council made up of representatives from the Texas Department of Health, the Texas Department of Mental Health and Mental Retardation, the Texas Department of Human Services, the Texas Education Agency, and a parent of a child with a disability who is appointed by the governor.

Funding

ECI is funded by federal funds and from state general revenue. In FY 1990 the council will spend approximately $14.2 million in state funding and $5 million in federal funding. The Texas ECI Program grants funds through a competitive proposal process each year. Local ECI programs also receive funds from United Way, city and county governmental entities, and contributions. The interagency council is currently funding 75 ECI programs throughout the state. The programs are providing services to 253 of the 254 counties with a special extension project to Maverick county (the only county not directly served by the program) (Texas ECI Program, February 1990).

Population Served

It is estimated that 3 percent of the population is born with developmental delays or established handicapping conditions. The Texas ECI Program serves .86 percent of the total 0-3 population. In FY 1989, 11,158 children received comprehensive services, follow-up services, or services under the purchased services program. Another 4,497 children who are at risk of delay were tracked through five special projects. In a survey of 381 children and families enrolled in ECI the following was determined: one-third of the children served by the ECI program had received care in neonatal intensive care units or special care nurseries, most of the children had recurrent or chronic medical problems, and most had gross motor or speech as their primary areas of delay. (Texas Department of Health, ECI, 1989)

Services Provided

The services for children that are provided by the program include screenings and evaluations; physical, occupational, speech, and language therapy; activities to improve cognitive and social skills; and training in self-help skills. For families the services include training in how to help their children; support through parent groups, and counseling as needed.

These services may be connected to the school system, a private nonprofit agency or to a CMHMRC. Currently ECI contracts 48 percent of its services from CMHMRCs and state schools, 30 percent from private nonprofit groups such as Easter Seals and rehabilitation centers, and 22 percent from school districts (Interview, ECI Director, March 16, 1990).

Eligibility

The Texas Early Childhood Intervention Program provides services to communities that help families of children ages birth to three who are developmentally delayed (cognitive, motor, social, emotional, speech, etc.) or who are likely to experience developmental delay (due to a specific syndrome, medical condition, environmental reasons, abusive families, etc). Children over three may be served if they are ineligible for public school preschool special education programs (Texas ECI Program, February 1990).

A child is eligible for ECI services if he/she has a significant developmental delay or has a biological condition that places him/her at risk of developmental delay. By Texas law, a developmentally delayed child is a child who is determined by an interdisciplinary team to exhibit the following: 1. a significant delay, beyond acceptable variations in normal development, in one or more of the following areas: cognitive, gross or fine motor, language or speech, social or emotional, self-help skills, or 2. an organic defect or a condition that is very likely to result in a delay in one or more of those capabilities or skills (TDMHMR, August 1988).

Results

Forty-six percent of children in ECI programs who were dismissed were referred to public school special education programs. A total of 18 percent or 788 of those graduated in 1989 did not need continued services. If these 788 children had needed continuing comprehensive services, the annual cost of services estimated by the Texas Education Agency at $6,000 per year per child would have been $4,728,000 (Texas Department of Health, 1989).

Relationship to Medicaid

Children served by ECI may be eligible for two Medicaid options: early and periodic screening, diagnosis, and treatment services (EPSDT) and purchased health services. A sample of ECI children indicated that in 1987, 46 percent met the financial eligibility requirements under Medicaid. In order for ECI services to be reimbursed by Medicaid, three general conditions must be met: the child receiving the services must be Medicaid-eligible, the service provided must be a Medicaid eligible service, and the service must be provided by a Medicaid provider (Texas Research League, March 1989).

At least 40 percent of the children in the ECI program were Medicaid-eligible as of March 1989. Several of the services provided by ECI are not in the state Medicaid plan. They include developmental assessment screening; speech, physical, and occupational therapy when provided in settings other than a hospital; and services offered under case management arrangements. The majority of ECI providers are not Medicaid providers and therefore cannot receive Medicaid reimbursement (Texas Research League, March 1989).

The recent Medicaid expansion will increase the number of children eligible for ECI services.

Table 7.1. Projected E[illegible]gram Enrollment from Medicaid Pr[illegible]m Expansion

Fiscal Year	Projected No. of Children Under 3 Years	Estimated percent Need ECI Services	
		High-17%	Low-3%
FY 1989	33,055	5,619	992
FY 1990	41,699	7,089	1,251
FY 1991	50,189	8,523	1,506

Sources: Select Committee on Medicaid Services Report, June 1988.
ECI Program Annual Report, 1987.

For the reasons cited above and others, the ECI program will change dramatically when it is made eligible for Medicaid reimbursement. The primary change will occur in how ECI contracts for services. The current method for service provision is for the contracted providers to be paid in advance for providing specific ECI services. Many of these services are provided through school districts and other nontraditional health care providers. Inclusion of this program in Medicaid will require all current providers to become eligible Medicaid providers. Payment will have to be made on a fee for service basis rather than on the basis of contracting for services to be provided in the future.

Conclusion

There are currently no data on the number of children in the ECI program who are emotionally at risk. However, social or emotional delay are included in the ECI-eligible population, and therefore ECI should be considered in the plan for potential services for severely emotionally disturbed children.

CHAPTER CONCLUSIONS

These four entities offer services which could benefit SED children and adolescents in Texas. While none of them explicitly target the youth who are the focus of this policy review project, they all provide potentially important treatment and training. It is critical that those who work with and advocate for SED youth be aware of these programs and know how to use them to the best advantage of these children and adolescents.

The Texas Commission on Alcohol and Drug Abuse claims not to serve SED youth but rather drug- and alcohol-abusing youth. But professionals who work with these children and adolescents are well aware of the fact that drugs and alcohol are mitigating or aggravating factors to emotional disturbance. TCADA is a clearinghouse for large amounts of federal funds which can be tapped into in order to funnel substance abuse treatment and prevention funds for SED youth.

The programs funded by the Job Training Partnership Act and administered by the Texas Department of Commerce can provide needed vocational training for disadvantaged SED youth. Especially important are the programs operating with the cooperation of the Texas Education Agency and individual school districts. The Texas Rehabilitation Commission offers many valuable training and rehabilitation services for disabled persons. As is shown in Appendix 7.10, 49 percent of the clients served by TRC have some type of mental disability. Many of the youth who are classified as SED can fit into these categories. This commission is an important resource for trainable SED youth.

The Texas Early Childhood Intervention Program can be used for the early identification of emotional disturbance. As the program evolves and changes with the addition of Medicaid funds, more emphasis needs to be place on intervention into emotional problems which become evident early in a child's life. Those who administer the ECI Interagency Council need to be made aware of the potential good that this program can provide to this vulnerable population.

Advocates need to look into what funds and services are available within these entities and others. SED children and adolescents are in need of services that are found within TCADA, JTPA, TRC, and ECI. The entities need to be convinced to become more involved in serving more of these children. And by explicitly dealing with the problems and manifestations of severe emotional disturbance the goals of these other programs may also be better achieved. Other funds need to be found and made available through more federal, state, and local sources to establish a better continuum of care of these troubled children and adolescents.

Appendix 7.1. Texas Commission on Alcohol and Drug Abuse
FY90 Awards - Youth Prevention/Intervention
By City and Recipient

Award Recipient/Location	Services Provided	Award Amount
Taylor Juvenile Justice Ctr. Abilene	Counseling, education life skills, training, parenting	$ 95,121
Austin Area Urban League Austin	Referral, assessment, counseling, support groups	$ 161,441
Austin Wilderness Counseling Austin	Assessment, testing, support groups, camps, expansion of existing CSA and SAY grants	$ 109,500
Montgomery Co. Youth Services Conroe	Education, crisis intervention, support groups, counseling, alternatives	$ 163,680
Coastal Bend Council on Alcohol/Drug Abuse Corpus Christi	Education, support groups, alternative activities	$ 62,530
Navarro College Corsicana	Youth - education, alternatives and advocacy/counseling	$ 70,000
Rainbow Days, Inc. Dallas	Education, curriculum, life skills, assessment, counseling, alternatives	$ 110,097
Coastal Bend Youth City Corpus Christi	Education, counseling, alternatives, support groups	$ 77,959
Aliviane NO-AD, Inc. El Paso	Education, instruction, training, support groups	$ 292,000
Life Management Center El Paso	Education, curriculum-based support groups, recreational sessions for families	$ 91,618
Families in Crisis, Inc. Killeen	Peer assistance, intervention, parenting skills	$ 83,750
Laredo State Center Laredo	Screening, assessment, referral, core activities, counseling, education, recreation, social, support groups	$ 347,147
Houston County MHMR Ctr. Lufkin	Information, skills training	$ 52,055
Permian Basin Center For Battered Women Midland	Information, assessment, intervention, counseling, support groups	$ 72,360
Gulf Coast Trades Center New Waverly	Education, training, screening, assessment, counseling, aftercare	$ 124,517

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Appendix 7.1 (Continued). Texas Commission on Alcohol and Drug Abuse FY90 Awards - Youth Prevention/Intervention By City and Recipient

Award Recipient/Location	Services Provided	Award Amount
Sand Dollar, Inc. Pasadena	Education, life skills training, counseling, support groups, AIDS awareness, aftercare	$ 60,000
Ella Austin Community Ctr. San Antonio	Referral, assistance, counseling, prenatal care, skills for parenting, social and personal, vocational preparation	$ 190,149
Northeast I.S.D. San Antonio	Assessment, intervention, support groups, identification, referral	$ 45,349
Women and Children's Resource Center San Antonio	Education, counseling	$ 34,500
36TH Judicial District Juvenile Probation Unit Sinton	Training, screening, assessment, counseling, life skills, support groups, retreats, outreach, referrals	$ 147,307
Neighborhood Centers, Inc. South Houston	Education, support groups, parenting skills	$ 52,272
Weatherford I.S.D. Weatherford	Curriculum, training, assessment, counseling, support groups	$ 53,889
# of Awards: 22	**Total Amount Awarded:**	**$2,497,241**

Source: TCADA, September 1988b.

Appendix 7.2. FY90 Awards - Substance Abuse for High Risk Youth By City and Recipient

Award Recipient/Location	Services Provided	Award Amount
Alice Counseling Center Alice	Youth - education, alternatives and advocacy/counseling	$ 121,734
Arlington Girls Club, Inc. Arlington	Youth female - education and alternatives	$ 23,640
Austin Child Guidance Center Austin	Youth - education, alternatives, advocacy, counseling	$ 101,863
Austin Family House, Inc. Austin	Youth - education, alternatives, advocacy/counseling for youth	$ 37,839
Austin Wilderness Counseling Services Austin	Youth - education, alternatives, advocacy, counseling	$ 117,955
Greater Austin COADA, Inc. Austin	Youth - education, alternatives, advocacy/counseling	$ 66,400
Youth Advocacy, Inc. Austin	Youth - alternatives, advocacy/counseling	$ 116,785
Cameron Co. Housing Authority Brownsville	Youth - education, alternatives, advocacy/counseling	$ 70,340
Gulf Coast Council of La Raza Corpus Christi	Youth - crisis intervetion/referral, information, education, counseling, alternative activities	$ 33,888
Freedom Ministries Dallas	Youth - education, alternatives, advocacy/counseling	$ 140,000
West Dallas Community Centers Dallas	Youth - information, education, alternatives, advocacy/counseling	$ 206,824
City of Del Rio Del Rio	Youth - crisis intervention/referral, education, alternatives, advocacy/counseling, information	$ 110,221
Tropical Texas Center for MHMR Edinburg	Youth - education, advocacy/counseling	$ 183,999
Aliviane NO-AD, Inc. El Paso	Youth - crisis intervention/referral, information, education, alternatives, advocacy/counseling	$ 44,225

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Appendix 7.2 (Continued). FY90 Awards - Substance Abuse for High Risk Youth
By City and Recipient

Award Recipient/Location	Services Provided	Award Amount
Hunt Co. Council on Alcohol/ Drug Abuse Greenville	Adult/youth - eductation, alternatives, advocacy/counseling	$ 60,531
Association for the Advancement of Mexican Americans Houston	Youth - crisis intervention/referral, information, education, alternatives, advocacy/counseling	$ 78,350
Chicano Family Center, Inc. Houston	Youth - information, education, alternatives, advocacy/counseling	$ 182,708
Martin Luther King, Jr. Community Center Houston	Youth - crisis intervention/referral, information, alternatives	$ 49,703
Shape Community Center Houston	Youth - crisis intervention/referral, information, alternatives	$ 50,000
Kleberg County Human Services Kingsville	Youth - crisis intervention/referral, information, education, counseling	$ 20,345
Lubbock Regional MHMR Center Lubbock	Youth - education, alternatives, advocacy/counseling	$ 33,179
Permian Basin Community Center for MHMR	Youth - education, alternatives, advocacy/counseling	$ 233,344
Dunbar Neighborhood Council, Inc. Mineral Wells	Youth - crisis intervention/referral, information, education, alternatives, advocacy/counseling	$ 104,024
Gulf Coast Trades Center	Youth - education, alternatives, advocacy/counseling	$ 63,926
Central Plains MHMR Center Plainview	Youth - crisis intervention/referral, information, education, alternatives, advocacy/counseling	$ 240,000
Mexican American Unity Council San Antonio	Youth - crisis intervention/referral, information, education, alternatives, advocacy/counseling, parenting skills	$ 305,000
San Marcos Youth Services Bureau San Marcos	Youth - education, alternatives, advocacy/counseling	$ 42,162
36Th Judicial District Juvenile Probation Unit Sinton	Crisis intervention/referral, information, education, alternatives, advocacy/counseling for youth	$ 40,970

Appendix 7.2 (Continued). FY90 Awards - Substance Abuse for High Risk Youth By City and Recipient

Award Recipient/Location	Services Provided	Award Amount
Sweetwater Council on Alcohol/ Drug Abuse Sweetwater	Youth -information and alternatives	$ 44,200
Swisher Co. Commissioner's Court Tulia	Youth - education, advocacy/counseling	$ 28,807
Palmer Drug Abuse of Victoria, Inc. Victoria	Youth - information services	$ 15,565
Economic Opportunities Advancement Corp. Waco	Youth - education, alternatives, advocacy/ counseling	$ 129,801
# of Awards 32	Total Amount Awarded:	$3,098,328

Source: TCADA, September 1988b.

Appendix 7.3. FY90 Awards -Student Assistance Programs By City and Recipient

Award Recipient/Location	Services Provided	Award Amount
Workers Assistance Program of Texas, Inc. Austin	Youth - student assistance programs	$ 582,251
Hurst-Euless-Bedford I.S.D. Bedford	Youth - student assistance programs	$ 70,000
Carrollton Farmer's Branch I.S.D. Carrollton	Youth - student assistance programs	$ 70,000
Galveston I.S.D. Galveston	Youth - student assistance programs	$ 64,964
Garland I.S.D. Garland	Youth - student assistance programs	$ 70,000
Williamson Co. Council on Alcohol/Drug Abuse Georgetown	Youth - student assistance programs	$ 46,455
Bay Area Council on Drugs & Alcohol, Inc. Houston	Youth - student assistance programs	$ 88,208
Communities in Schools-Houston Houston	Youth - student assistance programs	$ 112,000
Kerrville I.S.D. Kerrville	Youth - student assistance programs	$ 69,901
East Texas Council on Alochol/ Drug Abuse Longview	Youth - student assistance programs	$ 82,282
Stephen F. Austin State University Nacogdoches	Youth - student assistance programs	$ 57,299
Ector County I.S.D.	Youth - student assistance programs	$ 70,000
Northeast I.S.D. San Antonio	Youth - student assistance programs	$ 60,488
Hays-Caldwell Council on Alcohol/Drug Abuse San Marcos	Youth - student assistance programs	$ 111,473

Appendix 7.3 (Continued). FY90 Awards -Student Assistance Programs By City and Recipient

Award Recipient	Services Provided	Award Amount
Schertz-Cibolo Universal City I.S.D. Schertz	Youth - student assistance programs	$ 47,125
Sulphur Springs I.S.D. Sulphur Springs	Youth - student assistance programs	$ 31,202
Smith Co. Council on Alcohol/ Drug Abuse Tyler	Youth - student assistance programs	$ 80,262
Weatherford I.S.D. Weatherford	Youth - student assistance programs	$ 53,346
# of Awards: 18	**Total Amount Awarded:**	**$1,767,256**

Source: TCADA, September 1988b.

Appendix 7.4. Texas Commission on Alcohol & Drug Abuse
FY90 Awards - Pilot Primary Prevention
By City and Recipient

Award Recipient/Location	Services Provided	Award Amount
Amarillo Council on Alcohol/ Drug Abuse Amarillo	Youth - pilot primary prevention	$ 52,739
Brazos Valley Council on Alcohol/Drug Abuse Bryan	Adult/youth - pilot primary prevention	$ 53,865
Tigua Indian Reservation El Paso	Adult/youth - education, alternatives, crisis intervention/referral, advocacy/ counseling	$ 34,656
Clay Co. Drug & Alcohol Awareness Council Henrietta	Youth - pilot primary prevention	$ 32,714
Houston Council on Alcohol/ Drug Abuse Houston	Youth - pilot primary prevention, school-based curriculum, parent peer training	$ 86,893
Shape Community Center Houston	Youth - pilot primary prevention	$ 44,921
VGS, Inc. Houston	Youth - pilot primary prevention	$ 70,000
Colorado Valley Council on Drug/Alcohol Abuse La Grange	Youth - pilot primary prevention	$ 44,200
Roma I.S.D. Roma	Youth - pilot primary prevention	$ 130,000
Our Lady of the Lake University San Antonio	Education, information, activities, referral	$ 60,387
# of Awards: 10	**Total Amount Awarded:**	**$ 610,375**

Source: TCADA, September 1988b.

Appendix 7.5. Texas Commission on Alcohol and Drug Abuse
FY90 Awards - Children of Substance Abusers
By City and Recipient

Award Recipient/Location	Services Provided	Award Amount
Serenity House of Abilene, Inc. Abilene	Youth - children of substance abusers	$ 55,424
Catholic Family Service, Inc. Amarillo	Youth - children of substance abusers	$ 58,221
Austin Wilderness Counseling Services Austin	Youth - children of substance abusers	$ 85,840
Nueces Co. MHMR Community Center Corpus Christi	Education, support networks, referral Services	$ 27,357
Rainbow Days, Inc. Dallas	Youth - children of substance abusers	$ 315,928
Rainbow Days, Inc. Dallas	Youth - children of substance abusers	$ 176,640
Life Management Center El Paso	Youth - children of substance abusers	$ 100,953
Tarrant Council on Alcohol/ Drug Abuse Fort Worth	Youth - children of substance abusers	$ 88,879
Gulf Coast Regional MHMR Center Galveston	Youth - children of substance abusers	$ 120,000
Bay Area Council on Drugs & Alcohol, Inc. Houston	Youth - children of substance abusers	$ 88,192
Houston Council on Alcohol/ Drug Abuse Houston	Youth - children of substance abusers	$ 115,000
Riverside General Hospital Houston	Youth - children of substance abusers	$ 115,916
Permian Basin Center for Battered Women Midland	Youth - children of substance abusers	$ 55,754
South East Texas Regional Planning Commission Nederland	Youth - children of substance abusers	$ 61,351

Appendix 7.5 (Continued). Texas Commission on Alcohol and Drug Abuse FY90 Awards - Children of Substance Abusers By City and Recipient

Award Recipient/Location	Services Provided	Award Amount
Lamar Co. Alcohol/Drug Center Paris	Youth - children of substance abusers	$ 53,297
Ella Austin Community Center San Antonio	Information, educaton, support groups, referral	$ 33,288
San Antonio Council on Alcohol/ Drug Abuse San Antonio	Educational support	$ 148,386
Hays-Caldwell Council on Alcohol/Drug Abuse San Marcos	Youth - children of substance abusers	$ 145,756
Texas Lutheran College Seguin	Youth - children of substance abusers	$ 32,604
Smith County Council on Alcohol/Drug Abuse Tyler	Youth - children of substance abusers	$ 64,481
Heart of Texas Council on Alcohol/Drug Abuse Waco	Youth - children of substance abusers	$ 66,763
# of Awards: 21	**Total Amount Awarded:**	**$2,010,030**

Source: TCADA, September 1988b.

Appendix 7.6. Texas Commission on Alcohol & Drug Abuse
FY90 Awards - Youth Treatment
By City and Recipient

Award Recipient/Location	Services Provided	Award Amount
Austin Rehabilitation Center Austin	Residential and outpatient treatment for youth	$ 400,000
Texas Youth Commission Austin	Youth - residential, outpatient	$ 700,000
Youth Advocacy, Inc. Austin	Youth - supportive outpatient	$ 168,119
Jefferson County Council on Alcohol/Drug Abuse Beaumont	Youth - adolescent intensive outpatient	$ 98,368
Land Manor, Inc. Beaumont	Youth male - adolescent residential	$ 451,140
Nueces County MHMR Community Center Corpus Christi	Youth - adolescent residential	$ 19,047
Buckner Baptist Benevolences Dallas	Youth - adolescent residential	$ 636,676
Help is Possible, Inc. Dallas	Outpatient treatment for youth	$ 132,775
Denton County MHMR Center Denton	Youth - supportive outpatient	$ 62,000
United Medical Centers Eagle Pass	Youth - outpatient	$ 75,000
El Paso County Alcohol & Drug Treatment Program El Paso	Residential treatment for youth	$ 341,027
Life Management Center El Paso	Youth - supportive outpatient	$ 150,000
Family Service, Inc. Fort Worth	Youth - supportive outpatient	$ 13,549
Lena Pope Home, Inc. Fort Worth	Residential treatment for youth	$ 300,634
Association for the Advancement of Mexican-Americans Houston	Supportive outpatient services for youth	$ 212,671

Appendix 7.6 (Continued). Texas Commission on Alcohol & Drug Abuse
FY90 Awards - Youth Treatment
By City and Recipient

Award Recipient/Location	Services Provided	Award Amount
Association for the Advancement of Mexican-Americans Houston	Youth male - adolescent residential for inhalant abusers	$ 231,530
Chicano Family Center, Inc. Houston	Youth - supportive outpatient	$ 58,149
Odyssey House Texas Houston	Residential treatment for youth	$ 451,140
Laredo State Center Laredo	Youth male - adolescent residential	$ 684,375
Permian Basin Community Centers for MHMR Midland	Residential treatment for youth	$ 415,123
Dunbar Neighborhood Council, Inc. Mineral Wells	Youth male - adolescent residential	$ 197,418
Daytop Village, Inc. Richardson	Youth - outpatient	$ 574,172
Genesis House, Inc. Pampa	Youth - adolescent residential	$ 140,000
Central Plains MHMR Center Plainview	Residential treatment for youth	$ 414,648
Inman Christian Center San Antonio	Youth - adolescent residential	$ 500,000
Mexican American Unity Council San Antonio	Residential treatment for youth	$ 684,161
# of Awards: 26	Total Amount Awarded:	$8,111,722

Source: TCADA, September 1988b.

Appendix 7.7. Texas Commission on Alcohol and Drug Abuse Estimated Appropriations and Method of Financing for Fiscal Years 1990 and 1991

Object of Appropriation	FY 1990	FY 1991
Program Administration	$3,700,086	$3,706,249
Intitutional Treatment and Rehabilitation Program		
a. TDMHMR	429,953	429,953
b. Texas Department of Health	41,843	41,843
Total Rehabilitation Program	471,796	471,796
Community-Based Grants for Substance Abuse Services		
a. Prevention	9,686,171	10,406,171
b. Intervention	5,235,407	5,635,407
c. Treatment	29,639,014	30,115,981
Total Abuse Service	44,560,592	46,157,559
Grand Total, TCADA	$48,732,474	$50,335,604
Method of Financing		
State General Revenue Fund (30 percent)	15,053,953	16,653,343
Federal Funds [ADMBG] (68 percent)	33,360,808	33,364,548
Reappropriated Receipts	38,581	38,581
Alcohol and Drug Abuse Treatment Licensure Fund No. 487	187,500	187,500
Earned Federal Funds	91,632	91,632
Total	$48,732,474	$50,335,604

Source: TCADA, October 1989.

Appendix 7.8. Service Delivery Area Title IIA Participant Profile as of July 1, 1989 through December 31, 1989

Service Delivery Area	Number of Youth Participants	Percent Handicapped
Alamo	1,398	4.8
Ark-Tex	769	12.5
Austin/Travis County	314	4.5
Brazos Valley	284	4.2
Cameron County	1,373	3.6
Central Texas	239	2.1
Concho Valley	N/A	
Corpus Christi	536	2.2
Dallas	576	4.7
Dallas County, Balance of	168	16.1
Deep East Texas	239	12.1
East Texas	593	24.5
Fort Worth	781	13.4
Golden Crescent	N/A	
Gulf Coast	N/A	
Harris County, Balance of	691	4.8
Heart of Texas	N/A	
Hidalgo/Willacy Counties	N/A	
Houston	4,060	3.1
Houston-Galveston	1,706	20.8
Lubbock/Garza Counties	246	14.2
Middle Rio Grande	623	1.1
North Central Texas	571	32.9
North Texas	N/A	
North East Texas	N/A	
Pan Handle	382	1.3
Permian Basin	573	6.1
Rural Capital Area	236	8.5
Rural Coastal Bend	496	1.8
South East Texas	402	9.5
South Plains	230	5.2
South Texas	478	10.0
Tarrant County, Balance of	134	34.3
Texoma	98	18.4
Upper Rio Grande	1,371	3.4
West Central Texas	531	24.0

Source: TDOC, January 1990.

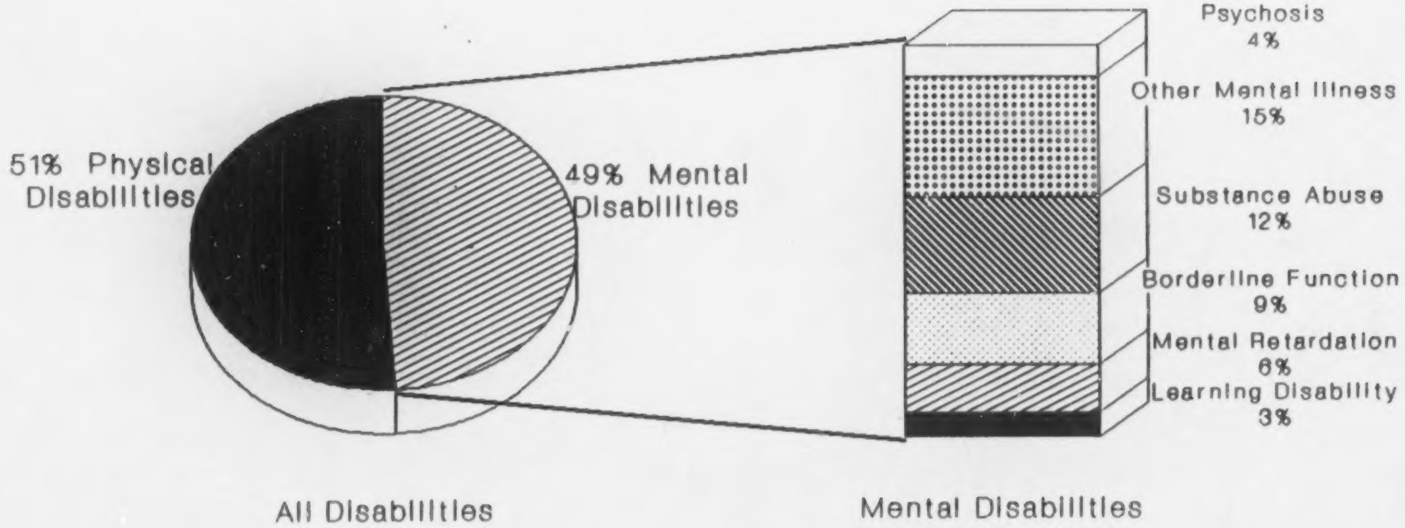
N/A = Not Available

Appendix 7.9. Job Training Partnership Act Allotments for Fiscal Years 1988 and 1989

JTPA Category	FY 1988	FY 1989	Percent Change
Title IIA-- Core Training Adult/Youth Programs	$164,186,519	$170,320,426	3.7
22% State Level Set-Aside	36,121,034	37,470,494	3.7
-Section 123 (8%)	13,134,921	13,625,634	3.7
-Older Workers Training (3%)	4,925,596	5,109,613	3.7
-Performance Incentive Grants to SDAs (6%)	9,851,191	10,219,226	3.7
-Special Programs Administration Audit & State Council (5%)	8,209,326	8,516,021	3.7
78% Allocation to 34 SDAs	128,065,485	132,849,932	3.7
Title IIB--Summer Youth Programs	65,527,821	65,527,821	0.0
Title IIC--Dislocated Workers	23,667,595	29,588,232	25.0
Title IVC--Veterans Programs	977,498	538,000	-45.0
JTPA Total	$254,359,433	$265,974,479	4.0
Wagner-Peyser	50,107,228	50,709,087	1.2
Grand Total	$304,466,661	$316,683,566	4.0

Source: TDOC, 1988.

Appendix 7.10. Primary Disabilities of TRC Clients Served During FY 1988



Source: TRC, 1989, p. 3.

References

Boyd, Jim. 1989. Senior Planner, Work Force Development Division, Texas Department of Commerce, Austin, Texas. Telephone interview by Michael Albrecht, November 13.

Davis, Becky. 1989. Deputy Director of Intergovernmental Relations, Texas Commission on Alcohol and Drug Abuse, Austin, Texas. Telephone interview by Michael Albrecht, November 4.

Dicks, Horace. 1989. Program Management Supervisor, Work Force Development Division, Texas Department of Commerce, Austin, Texas. Interview by Michael Albrecht, November 7.

Early Childhood Intervention Council. 1987. ECI Program Annual Report, 1987. Austin, Texas.

Fenoglio, John. 1990. Deputy Commissioner of Programs, Texas Rehabilitation Commission, Austin, Texas. Telephone interview, January 29.

Goodman, Larry. 1989. Deputy Director of Operations, Texas Commission on Alcohol and Drug Abuse, Austin, Texas. Interview by Michael Albrecht, November 9.

Intercultural Development Research Association (IDRA). 1989. An Independent Evaluation of At-Risk Youth Pilot Programs, May 1988-May 1989. San Antonio, Tex.

Roberts, Paul. 1989. Administration Specialist, Texas Commission on Alcohol and Drug Abuse, Austin, Texas. Interview by Michael Albrecht, November 7.

Texas Commission on Alcohol and Drug Abuse (TCADA). 1988a. "Policy Statement and Response to the Alcohol and Substance Abuse Oversight Committee." Commission News, vol. 3, no. 20 (August 30).

____________. 1988b. Requests for Legislative Appropriations: Fiscal Years 1990 and 1991. Austin, Tex.

____________. Program Development Department. July 1989. "Comprehensive Alcohol and Drug Abuse Services in Texas." Austin, Tex. (Mimeograph.)

____________. August 1989. Performance and Funds Management Report: Fiscal Year 1989. Austin, Tex.

____________. September 1989a. Comprehensive Alcohol and Drug Abuse Services Request for Proposals (CS 90). Austin, Tex.

____________. September 1989b. "FY 90 Awards by City and Recipient Name." Austin, Tex. (Mimeograph.)

____________. October 1989. "Substance Abuse in Texas: The Problem and the State's Response." Austin, Tex.

Texas Department of Commerce (TDOC), Work Force Development Division. 1988. An Annual Report on JTPA Performance in Texas. Austin, Tex.

____________. Work Force Development Division. August 1989. "Job Training Partnership Act Fact Sheet." Austin, Tex.

____________. Work Force Development Division. January 1990. "Participant Status Report from 7/1/89 to 12/31/89." Austin, Tex. (Computer printout.)

____________. Work Force Development Division. n.d. Untitled Draft (Mimeograph.)

Texas Department of Health. 1989. "Facts about Early Childhood Intervention in Texas 1989-1990." Austin, Texas.

Texas Department of Mental Health and Mental Retardation (TDMHMR). August 1988. ECI: Helping Families from the Beginning. Austin, Texas.

The Texas Early Childhood Intervention (ECI) Program. February 1990. "Program Description." Austin, Texas.

Texas Education Agency (TEA). 1990. "New 19 TAC Section 89.246: Memorandum of Understanding on Transition Planning for Students Enrolled in Special Education." Austin, Texas. September 19. (Working Document).

Texas Rehabilitation Commission (TRC). 1988. Annual Report 1987. Austin, Texas.

____________. October 1988. Request for Legislative Appropriations, Fiscal Years 1990 and 1991. Austin, Texas.

____________. 1989. Annual Report 1988. Austin, Texas.

____________. 1990. "Office Memorandum: FY '89 Annual Reports," Austin, Texas. (Mimeograph.)

____________. n.d. 1988 Programs Reference Guide. Austin, Texas. (Pamphlet.)

Tex. S.B. 222. 1989. 71st Leg., Reg. Sess.

Texas Research League. March 1989. The Benefits of and the Obstacles to Medicaid Program Expansion. A Report to Lieutenant Governor William P. Hobby. Austin, Texas.

Texas State Legislature, Select Committee on Medicaid Services. June 1988. "Report of the Seclect Committee on Medicaid Services." Austin, Texas.

Chapter 8. State-Level Coordination of Children's Services

INTRODUCTION

The structure of Texas state government has significant implications for the effective coordination of state services. The administrative organization of the state is characterized by a weak executive office and a complex mass of state agencies, commissions, boards, and departments which are created and maintained by the legislature. Each of the agencies enjoys considerable autonomy in its operations, often resulting in the fragmentation of services and the lack of comprehensive state policies. This is particularly evident in the area of human services where individuals' multiple needs often transcend bureaucratic boundaries. The State of Texas has attempted to address this problem through the creation of the Health and Human Services Coordinating Council in 1980 and through the enactment of memoranda of understanding among the agencies. The purpose of this chapter is to provide an overview of efforts to affect state-level coordination of services for seriously emotionally disturbed children and youth.

TEXAS POLITICAL SYSTEM

The governor, lieutenant governor, and speaker of the House comprise the leadership of Texas state government. The bicameral Texas Legislature convenes biennially for a general session, which may last no more than 140 days. The governor has the power to call the legislature into special session for a period of up to 30 days. During the special session, the governor determines the topics for consideration and the legislature may act on only those issues. The governor in Texas, who is elected for a four-year term, has very limited formal powers. In addition to calling a special session, the governor's formal powers include the veto for both general legislation and line items in the appropriations bill and sending messages to the legislature. The governor is vested with the power to make a number of appointments to the various boards and commissions, with Senate approval. However, the executive office has virtually no control over the operations of state administrative agencies.

The lieutenant governor is elected directly by the voters, independent of the governor, for a four-year term. The lieutenant governor serves as the presiding officer of the Senate and appoints chairpersons and most members of the Senate committees. The speaker of the House is elected by the members of the House for a two-year term. The speaker's powers in the House are similar to those of the lieutenant governor in the Senate. The speaker acts as presiding officer of the House and appoints the chairpersons and most members of the House committees.

The Legislative Budget Board (LBB) prepares the state budget for the legislature. Although the governor prepares an executive budget, the legislature typically ignores the executive document in favor of the LBB budget. The LBB budget contains recommendations for the state agencies' operating budgets for the biennium. Both the speaker and lieutenant governor are members of the LBB and each has the power to appoint two members.

The state's administrative organization consists of over 200 agencies, commissions, boards, departments, offices, councils, authorities, associations, and committees. There is no cabinet in Texas government as is found at the federal level and in many states. The legislature creates the agencies through enabling legislation, determines their structure and functions, and appropriates money. The majority of state agencies are governed by independent boards and commissions. The administrator of each agency is legally accountable to the board or commission. The lack of central authority for the activities of administrative agencies has significant implications for the delivery of human services.

HEALTH AND HUMAN SERVICES AGENCIES

A number of state agencies, shown in Table 8.1, are responsible for the provision of health and human services in the state of Texas. Nine of these agencies (denoted by *) are particularly involved in the development and provision of children's services.

Table 8.1. Texas Health and Human Service Agencies

Texas Department on Aging
Texas Commission on Alcohol and Drug Abuse *
Texas Commission for the Blind *
Texas School for the Blind
Texas Attorney General's Child Support Enforcement Division
Texas Department of Community Affairs
Texas Commission for the Deaf
Texas School for the Deaf
Texas Education Agency *
Texas Employment Commission
Texas Department of Health *
Texas Department of Human Services *
Texas Juvenile Probation Commission *
Texas Department of Mental Health and Mental Retardation *
Texas Rehabilitation Commission *
Texas Youth Commission *

Each of these agencies is responsible to an independent board and develops services for its primary clientele. However, in many cases, the multiple needs of seriously emotionally disturbed children and their families require the services of more than one agency. The creation of the Health and Human Services Coordinating Council represents the state's effort to minimize the impediments to effective coordination of services which result from the state's administrative structure.

TEXAS HEALTH AND HUMAN SERVICES COORDINATING COUNCIL

Impetus for the Health and Human Services Coordinating Council

In response to a growing awareness and concern regarding the lack of coordination and inefficiencies resulting from the duplication of services, the Texas Senate created the Special Committee on Delivery of Human Services in 1978. The purpose of the committee was to review the human service delivery system and examine the cost effectiveness of state services. The committee conducted a survey of existing state services and published its findings and recommendations in a 1980 report entitled Potential in the Patchwork: A Future Pattern for Human Services in Texas.

The committee's findings documented the fragmented service system which resulted from the provision of services by a variety of agencies at all levels of government (Texas Senate, Special Committee on Delivery of Human Services in Texas, November 1980, p. 7). The committee recommended the creation of a Legislative Coordinating Council to oversee the coordination and planning of state human service policy. In accordance with this recommendation, the Texas Legislature created the Texas Health and Human Services Coordinating Council in 1980.

Role of the Health and Human Services Coordinating Council

The Texas Health and Human Services Coordinating Council (THHSCC) coordinates and plans policies which have long-term implications for the delivery of health and human services in Texas. The THHSCC focuses primarily on services which involve the participation of more than one state agency. The THHSCC also attempts to coordinate the efforts of the various federal, local, and private agencies which currently provide services in Texas. The THHSCC provides a forum for agencies at the state level to consider the comprehensive scope of human services in Texas and to coordinate efforts for problems which are under the auspices of more than one state agency. In addition, the THHSCC works toward ensuring that state agencies spend money more effectively by eliminating the duplication of funds for overlapping services and targeting specific problems (Olsen, Interview, November 9, 1989).

Specifically, the enabling legislation for the THHSCC charged the THHSCC with the following mandates (S.B. 711):

1. Establish and maintain a central database of public and private health and human service agencies.

2. Conduct studies of significant health and human services.

3. Serve as a primary resource for coordinating and planning health and human services.

4. Analyze federal, state, county, municipal, agency, and public/private sector relationships to coordinate efforts to plan and deliver health and human services.

5. Provide a central information and referral source concerning health and human services.

6. Review existing and proposed actions and policies of federal agencies to determine the health and human services impact on Texas and recommend to the governor and the legislature alternative actions and policies consistent with state health and human services policy.

7. Provide advice to agencies, organizations, and governmental entities concerning the analysis of needs and the development, evaluation, and coordination of health and human services.

8. Conduct regular and comprehensive reviews and analyses of health and human services policy and make recommendations to the governor and to the legislature.

THHSCC Membership, Committees, and Operating Budget

THHSCC Membership. The membership of the THHSCC is comprised of state elected officials and the chairpersons of the boards and commissions as follows:

Governor
Lieutenant Governor
Speaker of the House
two Senators
two Representatives
Board of Human Services
Board of Health
Board of Mental Health and Mental Retardation
Board of Education
Rehabilitation Commission

Commission on Alcohol and Drug Abuse
Commission for the Blind
Commission for the Deaf
Department of Aging
six Citizen Representatives

The Senate representatives are appointed by the lieutenant governor, and the two House representatives are appointed by the speaker. The governor, lieutenant governor, and speaker each appoint two citizen representatives. The executive director of the THHSCC is a nonmember appointed by the governor. An additional seven THHSCC staff members assist with work on projects assigned to the THHSCC by the legislature.

Committees. In response to legislative mandates, the THHSCC typically creates an advisory committee of agency and citizen representatives to implement the mandate. Past THHSCC advisory committees have included the Council on Disabilities, Long-Term Care Coordinating Council for the Elderly, Advisory Committee on Maternal and Infant Health, Children and Youth Services Coordinating Council, and Public Private Policy Group.

Budget. The HHSCC received a two-year appropriation in the amount of $1,059,617 for FY 1990 and $1,182,639 for FY 1991. The appropriation included federal funding for administration of the State Legalization Impact Assistance Grant (SLIAG): $197,500 in FY 1990 and $195,000 in FY 1991. The appropriation also included funds earmarked for the establishment of a computer node and client registry: $574,782 for FY 1990 and $700,474 for FY 1991. The remainder of the THHSCC's budget consists of funds appropriated from contracts with other state agencies. These funds are transferred from the budgets of health and human services agencies to the THHSCC to contract for the provision of coordination and planning services. The THHSCC's budget includes funding for an executive director of the THHSCC and seven full-time staff members.

PROJECTS AND INITIATIVES

General Projects and Activities

Since its creation, the primary role of the THHSCC has consisted of researching and reporting the condition of human service delivery in the state. The THHSCC's efforts specifically related to emotionally disturbed children have focused on the development of a reimbursement system for residential care and the implementation of four pilot projects for children's services. The THHSCC's newly established Commission on Children, Youth, and Family Services is currently involved in developing a statewide philosophy for serving children, families, and youth.

Creation of Database of Available Services. In 1987, the THHSCC published Health and Human Services in Texas: A Reference Guide and a microcomputer database system compatible with the guide. The purpose of this was to provide a comprehensive source of information on the availability of public and private human services in Texas (THHSCC, 1988b, p. 9).

Study of State Health and Human Service System. In 1987 the governor, lieutenant governor, and speaker requested that the THHSCC research the health and human service systems and develop recommendations to improve their effectiveness and efficiency. The THHSCC's Restructuring Committee published a report of their findings entitled Strategic Partnerships: Health and Human Services for the Future. Recommendations of this report included the addition of the state agencies for the blind, deaf, and alcohol and drug abusers to the THHSCC, the establishment of a central computer node and client registry, and the establishment of standardized rate methodologies.

Following the recommendations, THHSCC membership was expanded to include the additional agencies. Funds were appropriated in the 71st Legislature to implement a central computer node and client registry. The agencies are currently in the process of establishing this centralized database. Upon completion, this will provide a common framework for the exchange of information among state agencies and will allow agencies to readily identify clients receiving multiple services. Each agency will enter information on services provided to individual clients. Other state health and human service agencies may access this information and determine which services a client has received in the past as well as services currently provided.

Seriously emotionally disturbed children frequently receive multiple services. This database will allow agencies to monitor the child's history with state agencies and, in addition, will provide more comprehensive information on the full scope of services. A major initiative of the THHSCC has been the implementation of the committee's recommendation for standardized rate methodologies in the area of residential contract care for children.

Residential Contract Care for Children

The standardization of rates and placement criteria for residential contract care represents the THHSCC's most significant effort to coordinate services for seriously emotionally disturbed children. As such, the development of this policy serves as an interesting case study which reflects issues inherent in state attempts to coordinate services. The idea of standardized rates initially gained attention in 1984 and was fully implemented in 1989. The following discussion outlines the process by which standardized placement and reimbursement procedures was developed.

Development of Standard Policies for Residential Contract Care. In 1984, the LBB recommended that the THHSCC develop a coordinated system for reimbursing residential care providers. The goal was to improve coordination of state agency efforts to place children and to limit wide variations among reimbursement rates. The LBB recommended that the THHSCC ". . . develop guidelines and procedures for the coordination of placement, monitoring, and oversight activities of agencies which provide contracted care for children [and which] . . . include a standardized schedule for reimbursement rates based on actual costs of various levels of care" (THHSCC, 1985, p. 1).

At that time there was little consistency to the residential care reimbursement structure. Each state agency determined reimbursement rates and paid residential care providers based on the facility's type of license. The tremendous variation among the agencies' rates led to competition among state agencies to obtain bed space for their clients. Many children were inappropriately placed as a result of placement determined by the availability of space in facilities rather than the child's needs.

In response to the LBB recommendation, the THHSCC undertook a study which examined the state system of reimbursement for residential care. In March 1985, the THHSCC published A Spectrum of Services for Texas Children in Residential Care, which identified the following problems in the system (THHSCC, March 1985, pp. 1-2):

1. Divergence among rates paid by each agency.
2. Disparity between reimbursement rates and actual costs.
3. Lack of levels of intermediate care.
4. Lack of incentive for private-sector development of additional types of care.

5. Lack of interagency mechanism for providing services and sharing information.

6. Lack of monitoring and outcome measures to ensure that children are receiving appropriate care.

The THHSCC recommended " . . . a simplified rate structure based on levels of care rather than the type of facility license" (THHSCC, March 1985, p. 18). The development of this structure required the development of definitions for various levels of care, cost reporting by service providers, determination of the providers' reasonable costs of service delivery, and a methodology for calculating a reimbursement rate for providers of various levels of care. The THHSCC also recommended the development of a uniform placement application for all agencies and a mechanism to allow for multiagency funding of a child.

In July of 1985, the THHSCC created the Public/Private Policy Group (PPPG), comprised of eight agency and eight private-sector representatives. This group advised the THHSCC on the development of a systematic approach to residential contract care for children and youth. In addition, the PPPG completed standards for monitoring the levels of care provided by facilities, developed and implemented a common placement application, and analyzed the costs of residential care. An additional responsibility of the PPPG was to develop a methodology to assess the level of care required by an individual child.

Levels of Care System. The comprehensive levels of care system was fully implemented in the fall of 1989 and included common application, common definitions and standards to determine the level of care of the facility, and a cost-reporting process. The common application form is provided in Appendix 8.1. This system applies primarily to nonprofit facilities; psychiatric hospitalization is not included in this process.

Rate-Setting Process. There are six levels of care (Levels I-VI), with rates of reimbursement for each level recommended to the TDHS board by the THHSCC. An annual cost analysis questionnaire is mailed to all agencies who contract to provide care for clients of the state (Appendix 8.2). These cost reports are then audited by the audit staff of TDHS, which disallows excessive costs for particular categories as well as nonreimbursable costs.

The audited data are evaluated by the staff of the THHSCC and a median cost is established for each level of care. Each facility's cost report is assigned to the peer group representing the highest level of care which that facility provides. This tends to bring the median cost for most peer groups below the actual cost of taking care of clients at that level. The facility is then reimbursed not at the median rate for the peer group it is assigned but rather at the rate the client is eligible for. The board of THHSCC subsequently recommends the daily cost-of-care rates to the state agencies. The board of each agency then may chose whether to accept the recommended daily rate for payment to providers, based on allocated state and federal funds.

Due to fiscal constraints, TDHS presently pays the provider of care approximately 82 percent of the median cost of the service for various levels of care. Texas Youth Commission on the other hand, pays 100 percent of the determined rates. Actual reimbursement rates, effective September 1989, are shown in Table 8.2. These rates are paid to facilities that provide a particular level of care and meet standards for services for that level. This reimbursement, in many cases, does not fully compensate residential care providers for the actual cost of providing services. The impact of this gap has been a shortage of services for the higher levels of care.

Table 8.2. Reimbursement Rates for Substitute Care, Effective September 1989

Level of Care	TDHS Daily Rate
Level 1	$ 13.00
Level 2	$ 35.00
Level 3	$ 48.00
Level 4	$ 70.00
Level 5	$ 84.00
Level 6	$121.00
Emergency Care	$ 13.00 - Foster family
" "	$ 48.00 - Foster group home
" "	$ 70.00 - Emergency shelter

Source: TDHS Protective Services, "Reimbursement Rates for Substitute Care," Austin, 1989. (Memorandum.)

There is currently a tremendous disincentive for providers to reevaluate a child's needs and make appropriate adjustments in the placement. If a child is transferred to a lower level of care, the facility receives a lower rate of reimbursement. The THHSCC is presently examining ways to establish a mechanism to determine when a child's needs have changed and the level of care must be modified (Olsen, Interview, November 9, 1989).

Determination of Level of Care. The levels of care continuum ranges from Level I, the least restrictive, to Level VI, psychiatric treatment, excluding hospitalization. The appropriate placement of children based on level of care is determined with the assistance of a two-page behavior-rating checklist. Placement in residential care is sought according to the needs of the child and the availability of space in the appropriate facility. It is significant to note that TDHS staff make placement decisions frequently without the services of a psychiatrist, psychologist, or DSM-III-R diagnosis. TDHS has only recently begun to behaviorally describe the more seriously emotionally disturbed child (Levels IV, V, and VI) in its care. Therefore, many of the descriptors are in rough draft form. (The definitions for the various levels of care for residential placement are provided in Appendix 8.3.)

Major Activities Related to Children

In addition to efforts to coordinate residential care, the THHSCC has undertaken several other activities related to seriously emotionally disturbed children. These initiatives include the implementation of pilot projects to coordinate local services and resources for children with multiple needs. The Commission on Children, Youth, and Family Services was created in 1989 to continue work on standardization of reimbursement of residential care providers and the expansion of the pilot projects. In addition, the commission was charged with several mandates to coordinate services to children and families.

Community Resource Coordination. The THHSCC created the Children and Youth Services State Coordinating Committee in 1987 in response to increasing concern about services for children and adolescents with multiple problems. The purpose of this committee was to address the needs of multiproblem children at the local level, and membership included the chairs of the boards and commissions of eight human service agencies together with members of the general public appointed by legislative leadership.

The Children and Youth Services Coordinating Committee developed a model for service delivery to multiproblem children. This program required the establishement of local interagency bodies to share resources to provide services for children whose needs are not met by a single agency. The goal of this program was to facilitate communication among local administrators from state agencies with responsibility for services to children and adolescents and local community service organizations.

During 1989, the program was implemented at four pilot sites: Travis County, Henderson County, Tarrant County, and Val Verde County. These projects are currently being evaluated. If the demonstrations are successful, this approach may be applied in other areas of the state. This program may be enhanced by the establishment of discretionary funding at the state level to provide intensive services for multiproblem children and to allow for the development and implementation of additional pilot programs.

Examination of Costs and Benefits of Combining Children's Services. In 1987, the legislature directed the THHSCC to study the costs and benefits of combining services to children and youth in the state and to focus on the possibility of creating a single children and youth services agency to provide coordinated services to children and youth (S.B. 298). In 1989, the THHSCC published Children and Youth in Texas: A Proposal for Coordinated

Services in response to this mandate. The analysis considered the organization of services in other states and the current service delivery system in Texas. Based on these findings, the THHSCC recommended modification rather than replacement of the existing organizational structures. Specific recommendations were as follows:

1. Reorganize the Children and Youth Services State Coordinating Committee and the Public/Private Policy Group into a single committee with authority to develop a continuum of care for children in Texas.
2. Create a formalized mechanism for community groups to communicate local problems and gaps in services to the Children and Youth Services State Coordinating Committee through the Community Resource Coordination Groups.
3. Create an information and referral network for children and youth services.
4. Develop an interagency policy development plan and financial resource statement for children and youth for use by committee members, agency budget officers, commissioners, and legislators in planning unduplicated services and preparing their respective agency Legislative Appropriation Requests.
5. Develop a state discretionary fund to be used for services to children and youth with multiple problems who are in critical need and for whom all other funding sources have been exhausted.
6. Develop generic forms for coordinated intake and eligibility.
7. Develop flexible local agency service hours.
8. Designate the Texas Department of Human Services as the sole agency responsible for licensing residential care programs. (THHSCC, February 1989, pp. i-ii)

The 71st Legislature took action to codify two of these recommendations. The model community resource plan was implemented by creating the Community Resource Coordination Groups (recommendtation 2). House Bill 2116 created the Commission on Children, Youth, and Family Services (recommendation 1).

Commission on Children, Youth, and Family Services. In 1989, the THHSCC's Children and Youth Services State Coordinating Committee (CYSSCC) and Public/Private Policy Group were combined to form a new commission, the Commission on Children, Youth, and Family Services. The commission is comprised of representatives from state agencies and members of the general public. In addition to continuing the efforts of the PPPG and the CYSSCC, the commission was charged with several other mandates. The commission is mandated to develop and adopt a state philosophy for children, youth, and their families. At the commission's first meeting on November 12, 1989, six specialized work groups were established that reflect the commission's added responsibilities. Each of the work groups was charged with focusing on elements of the statewide philosophy relating to children, youth, and their families while concentrating on their area of specialization.

The Prevention and Intervention group is charged with developing strategies for the expansion of prevention and early intervention programs and reviewing successful programs for replication. This work group is also involved in implementing the Memorandum of Understanding on services to dysfunctional families. The CASSP subcommittee, formerly part of the Children and Youth Services State Coordinating Committee, is organized under this group (THHSCC, February 1989, n.p.).

The Community Resources work group is assisting in the implementation of the Community Resource Coordination Groups and coordination of the critical needs report on these groups. This work group is responsible for the biennial reporting of local services (THHSCC, February 1989, n.p.).

The Policy Coordination work group is reviewing and recommending changes in state health and human service policy as well as examining the issue of interagency coordination and developing strategies for maximizing federal funds (THHSCC, February 1989, n.p.).

Policies and procedures pertaining to out-of-home placement are being analyzed by the Treatment and Care work group. This work group is also responsible for the levels of care process. Membership of the Public/Private Policy Group has been transferred to this work group (THHSCC, February, 1989, n.p.).

The Project Child Save steering committee is responsible for developing Project Child Save. This program will enlist local support for programs targeting at-risk children. The 12 members of this steering committee were appointed by the legislative leadership.

The Child Abuse Evaluation Committee was created to devise, implement, and coordinate standards for the evaluation of child abuse treatment, prevention, and protection programs (THHSCC, February 1989, n.p.).

The commission held its first meeting on November 12, 1989, and selected chairpersons of the workgroups.

MEMORANDA OF UNDERSTANDING

Memoranda of understanding (MOU) represent an alternative approach by the state to improve coordination of services to children, youth, and families. The legislature mandates two or more human service agencies to develop an MOU outlining cooperative efforts to be undertaken by the agencies to coordinate services. In the past two legislative sessions, a number of MOUs have been enacted. However, because the MOUs are not formulated on the basis of an overall state plan or philosophy, there does not appear to be any consistency or coherence to their development. In the 71st session, services to dysfunctional families, family-based services, interagency training, and services for runaways were the topics of MOUs. (A complete list of these MOUs for the 70th and 71st sessions is provided in Appendices 8.4.A and 8.4.B., respectively).

MODEL STATE PROGRAMS

The fragmentation of children's services is not unique to the state of Texas. Inadequate coordination of services appears to be widespread among states. Several states, however, have made efforts to develop innovative methods of funding children's services and to facilitate higher degrees of interagency coordination. Ohio, Alaska, and North Carolina provide examples of state attempts to institute measures to establish more coordinated service systems.

Ohio

On February 29, 1984, Governor Celeste issued an executive order directing the Ohio Departments of Human Services, Mental Health, Mental Retardation and Development Disabilities, Youth Services, Health, and Education to adopt new rules to assure that multiple-need children are served in a timely and coordinated manner. Out of this order, the Interdepartmental Cluster for Services to Youth was established to promote interagency coordination and collaboration. This organization gained legislative authority on October 20, 1987 (Celeste, Memorandum, September 1, 1989).

Requirements by Legislation. The directors or the representatives of the various state agencies serving children and adolescents will be appointed members of the Interdepartmental Cluster for Services to Youth (ICSY). The purpose of this state cluster will be to review issues and specific cases and report its findings to the governor and the General Assembly. It will also develop specific programs and services to meet the needs of multiproblem children (Ohio H.B. 304, 1987). In addition, the counties will have their own clusters and will report on their activities and refer unresolved cases to the state cluster.

Philosophy. The interdepartmental clusters are designed to assure that a continuum of quality services is available to the children and their families with severe and multiple problems. Service delivery (through local, regional, and state levels) is to be based on the individual child's needs, provided in a timely manner and in the child's home or community. When a child is removed from the home, it is the goal of the clusters that placement will be in the least restrictive, most family-like setting possible and as close to the child's home as possible so that the family can be involved in the treatment. A treatment plan is to be done jointly by the agencies responsible for serving the child.

Interdepartmental Cluster (State Level). Representatives from the Ohio Departments of Human Services, Youth Services, Mental Retardation and Developmental Disabilities, Education, Health, and Mental Health as well as representatives from the Governor's Office of Advocacy for Disabled Persons and the Rehabilitation Commission serve on the state cluster. Meetings are held on a weekly basis to discuss individual cases that have been referred by the county clusters and policy issues relating to children.

There have been referrals from 71 counties in Ohio since May 1984. The majority of the referrals were a result of the county being unable to provide services because of funding or resource shortages. The majority of these referrals request assistance in funding out-of-home placements and locating appropriate treatment centers (Celeste, Memorandum, September 1, 1989).

County Clusters. County clusters operate in all of Ohio's 88 counties. Representatives from the county boards of mental retardation and developmental disabilities, community mental health boards, local boards of education, public children services agencies, county/city health boards, and Department of Youth Services regional offices serve on the county clusters. The juvenile courts are not required to participate but are encouraged to do so (Frank, September 1989, p. 2).

Children served by the clusters must have a combination of two or more problems or conditions and be involved or qualify to be involved with two or more service providers. Age can range from birth to 21. Many of the children have had prior and/or multiple out-of-home placements.

Since May 1984, 305 children have been referred to the county clusters. Ninety-five percent have serious behavior problems, 75 percent have been abused or neglected, 39 percent have been adjudicated delinquent, 25 percent have physical or health-related problems, and 35 percent have some degree of mental retardation. Children with two presenting problems have consisted of 19 percent of the referrals, while 75 percent have had three or more problems or conditions (Frank, September 1989, p. 4).

Services Provided. Primary prevention begins with consultation and educational activities within the community. Secondary prevention involves activities that are directed at at-risk populations, such as youth who have recently experienced the death of a parent. Tertiary prevention services are programs designed for children and adolescents who are currently being treated for one condition. The goal is to prevent them from developing a second condition. All early identification and intervention programs are collaborative efforts between different agencies and recognize the parent's perspective as a crucial factor in the treatment's success (Celeste, Memorandum, September 1, 1989).

Most family support services are home-based and crisis-oriented. Only families that are on the verge of having a child removed from the home are served. These services have a family focus as opposed to a single-child focus, and staffers often visit the home of the child or adolescent.

In addition, respite care that is both in-home and out-of-home is made available for the family. Self-help and mutual support groups which emphasize that the parent is a partner with the professionals in the care and treatment of the child are offered to the parent as well. Recreational services, such as Big Brother and Big Sister programs, aim to provide the children and adolescents with role models. There are latchkey programs, special summer camps, and special recreational projects sponsored by different volunteer organizations.

Day treatment for two to eight hours per day plus therapeutic foster care/specialized family care, community group home care, and independent living programs are also available.

Funding. In September 1989, the Interdepartmental Cluster for Services to Youth set aside $3 million for two types of projects to help local clusters build a family-based, community-based system of care for children and youth (Celeste, Memorandum, September 1, 1989). When requesting funds from the state cluster, the county clusters were requested to submit programs which include the following components:

1. Development of a local system of care for systems planning, integration of program development initiatives, combined fiscal strategies, and service delivery enhancement.

2. The hiring of a local cluster coordinator with the primary focus of stimulating interagency planning, system development, and cluster management.

Future Planning by the State Interdevelopmental Cluster. The state has set up the following future goals and plans for Ohio's cluster system:

1. The state cluster will find and fill service gaps to avoid duplicative efforts among state and local agencies.

2. Aid will be given to county clusters to develop more family-based services, with a focus on early intervention programming.

3. Program development that offers a continuum of care will be actively promoted.

4. Additional state funding will be provided to allow clusters to hire and train staff who will have the expertise and time to devote to programming and issues that relate to multiproblem families.

5. Specialized consultation and services will be provided to county clusters for children with special needs.

6. County agencies will be aided in the development and identification of funding sources.

7. Feedback will be actively solicited on current state policies from the county clusters to enhance the feeling of cooperation among the state and county clusters.

8. Joint advocacy between state and local groups will be promoted.

9. Identification and development of special treatment programs for target populations will be provided where programming is currently inadequate or nonexistent. (Frank, September 1989, pp. 6-8)

Alaska

History. Traditionally, mental health services in Alaska have had an "adults only" label. In 1985, the Division of Mental Health and Developmental Disabilities received a Child Adolescent Service System Program (CASSP) grant award which prompted the establishment of the Child and Adolescent Mental Health Services Coordinator within the division. In addition, the Departments of Education and of Health and Social Services created the Alaska Youth Initiative (AYI) to ensure that all state departments, school districts, and community service organizations worked together to provide services for troubled youth.

Children in Need in Alaska. It is estimated that 24,000 children in Alaska need mental health services. Only 2,719 were seen in 1985 through the public mental health system. This number can be increased by counting the estimated 5,000 children that were served by private care providers, but currently private care providers for children in Alaska are scarce (VanDerBerg, 1989, p. 7). The primary services in Alaska now available for children through the public mental health system are outpatient services at community mental health centers. Inpatient services are available through the Alaska Psychiatric Institute in Anchorage.

Goals of the AYI. The primary goal of the AYI is to limit further inappropriate out-of-state and institutional placements and to provide transition for troubled youth who were previously placed out-of-state. The AYI also developed the necessary culturally appropriate program that would meet the needs of the most troubled youth.

Other goals include providing special, individualized case planning, monitoring, program development, and funding for youth and their families. Conflict resolution and eliminating confusion around client responsibility and funding for youth and their families are other areas that were targeted as needing improvement. Finally, there is a perceived need to evaluate the strengths and the gaps within the continuum of care within the communities (VanDerBerg, 1989, p. 14).

Management of AYI (Since March 1989). An interdepartmental team consisting of staff from the Department of Education, the Division of Mental Health and Developmental Disabilities, and the Division of Family and Youth Services as well as three regional coordinators coordinate local treatment and education teams. The teams devise individualized service plans for each youth (Alaska Department of Health and Human Services, 1989, pp. 1-5).

Funding of AYI. The AYI gets approximately $2 million in funding from three different sources: $835,000 from the Department of Education, $603,000 from the

Department of Mental Health and Developmental Disabilities, and $250,000 plus add-ons through residential and foster care from the Department of Family and Youth Services.

Success Rate. The current average length of participation in AYI is 11.8 months. The longest period of participation has been 31 months. The average number of failed out-of-home placements per youth prior to admission to AYI was 5. Before AYI existed the average number of failed placements per youth was 20.

As of March 1, 1989, 49 AYI youth have been diverted from proposed out-of-state placement or have been returned to Alaska. In addition, there has been collaborative planning and shared funding of individual treatment and education plans of all 45 active AYI youth.

An unconditional care approach of sticking with youth "no matter what" has been working. The traumatic occurrence of failed placements has been stopped in almost every case (Alaska Department of Health and Human Services, 1989, pp. 7-16).

CONCLUSIONS AND RECOMMENDATIONS

The absence of vested leadership and ultimate responsibility for development of policy related to children's services has resulted in a fragmented service system in the state of Texas. Although recent efforts (i.e., standardized reimbursement for residential care and development of community resource groups to coordinate services for multiproblem children) are encouraging, it appears that little progress has been made since this issue first became the focus of state attention in the early 1980s. The clear articulation of state goals and objectives for children's services as well as the delegation of responsibility among state agencies for bringing these objectives to fruition is essential to ensure that services are appropriately developed and implemented. The Commission of Children, Youth, and Family Services has the potential to accomplish this.

Many of the issues discussed in this analysis have occurred relatively recently and are at various stages of completion. A number of them are ongoing efforts (i.e., Commission on Children, Youth and Family Services activities). It is to be hoped that the emerging state fiscal constraints will not derail a number of important and potentially productive initiatives.

Appendix 8.1. State of Texas Common Application for Placement of Children in Residential Care

STATE OF TEXAS

Common Application for Placement of Children in Residential Care

DHS Form 2087

Appendix 8.1. State of Texas Common Application for Placement of Children in Residential Care (cont'd)

DESCRIPTION OF THE COMMON APPLICATION

The Common Application for contracted residential placement of children is the result of a two year cooperative effort between public agency representatives and representatives of the private sector.

The application is designed for comprehensiveness and for flexibility. It meets the requirements of all state agencies and local entities associated with a state agency involved in the placement of children. It provides considerable information about a child or adolescent to assist in selecting appropriate placements. The completed application can be copied and submitted to all potential providers of service for that child, rather than completing a separate application for each facility considered.

In many instances, agencies that place children in residential settings are currently using forms that contain all of the information required in a specific section of the Common Application. In such cases, the existing forms can be inserted into the appropriate section in the Referral/Admissions Packet. In other cases, only partial information is contained in an existing form. In this situation, the placing agency can insert the existing form and complete the parts of the section that are not covered by the existing form. To facilitate the process of completing the Common Application, agencies might want to adapt existing forms so that they conform to those contained in the Common Application.

In summary, the Common Application serves two purposes. It provides information to help determine if a facility can meet the child's needs, and it provides a single format for use by all state agencies and all private facilities which contract with the state.

The Common Application consists of three parts:

- Part A — Screening Profile
- Part B — Behavior Rating Scale
- Part C — Referral/Admissions Packet

Part A — Screening Profile

The Screening Profile is a summary of all the information about the child. It highlights the important considerations for placement and alerts the care provider where to find more detailed information in Part C, the Referral/Admissions Packet.

Part B — Behavior Rating Scale

The Behavior Rating Scale contains 64 items that are intended to present a broad description of the child's behavior and general characteristics. In addition, the scores of 15 of the items on the Behavior Rating Scale are used to determine the estimated "Level of Care" required by the child.

Part C — Referral/Admissions Packet

The Referral/Admissions Packet contains detailed information and documentation that elaborates on the contents of the Screening Profile. The information is organized into 12 sections. The twelve sections in the Referral/Admissions Packet are:

1. **Social and Developmental Assessment**
2. **Special Needs, Problems, and Behaviors**
3. **Juvenile Justice History**
4. **Placement History**
5. **Substance Abuse History**
6. **History of Abuse/Neglect to Referred Child**
7. **Family History**
8. **Financial Information**
9. **Education**
10. **Physical Health/Disabilities**
11. **Mental Health**
12. **Other Attachments**
    - **A. Birth Verification**
    - **B. Legal Records**
    - **C. Authorization Forms**

Appendix 8.1. State of Texas Common Application for Placement of Children in Residential Care (cont'd)

COMPLETING THE COMMON APPLICATION

All parts of the common application must be as complete as possible, since it is a continuous record of the child's history, placement, and progress. Sources of information include, but are not limited to, case records, personal experience, interviews with parents, teachers, caregivers, and others familiar with the child.

Part A — Screening Profile

Although the Screening Profile is the first part of the Common Application, it cannot be completed until the majority of the information required to complete Part C, the Referral/Admissions Packet, has been assembled, the Behavior Rating Scale has been administered, and the Level of Care has been determined. The information required to complete each section of the Screening Profile is derived from the corresponding section of the Referral/Admissions Packet. However, some comments on the Screening Profile follow to assist in the completion of this part of the Common Application.

Section 1. This section asks for a summary of your impressions. It should be written after completing the Social and Developmental Assessment (page 5). The first part asks for your overall impression of the child. The second specifically asks you to summarize the child's strengths.

Section 2. Simply check the appropriate boxes, record the number of instances of running away, and list any other problems identified on page 6, "Special Needs, Problems, and Behaviors."

Section 3. All of the information required to complete this section will be found on pages 7 and 8 of the Common Application. A referral occurs when a child and or the child's parents are brought before juvenile authorities for one or more acts which violate a legal code. There must be a written record of this contact. For example, if a child appears before juvenile authorities on July 21, 1989 for commiting ten burglaries, this counts as one referral, not ten. Similarly, the number of adjudications is the number of seperate dates on which the child was adjudicated regardless of the number of referrals or acts involved in the adjudication.

Section 4. The information for this section is contained on page 9 and any continuation pages required to include the child's complete placement record. Do not include stopover placements, informal placements with relatives, or returns to home in this section of the Screening Profile.

Section 5. This section asks about the child's history of substance abuse. Therefore, if a child abused a substance at any time that will be reflected in the severity rating, even if the child does not currently abuse the substance. The degree of severity of abuse is a judgment to be made based on the information contained on page 10 of the Referral/Admissions Packet and any other relevant information available. In general, for substance abuse to be judged severe, it would have to be considered as a primary problem when it occurred. Mild and moderate degrees of substance abuse would be secondary problems. The need for a specialized treatment program should be based upon documentation of habitual substance abuse or records contained in the Referral/Admissions Packet. However, if the available information indicates that such a program might be required, it would be appropriate to recommend a complete substance abuse evaluation.

Section 6. This section asks whether the child has been abused or neglected. The degree of abuse is a judgment based on the descriptions provided on page 11. If the abuse or neglect was the reason the child was removed from the home, the rating will be severe.

Section 7. Pages 11 — 14 of the Referral Admissions Packet should contain enough information to complete this section, although judgments or supplemental information may be required to answer some of the questions (such as, can the child return home?)

Section 8. In general, the information for this section is derived from the educational records in the Referral Admissions Packet. The IQ test information might be contained in psychological reports rather than in the educational records.

Section 9. Check whether the child has a diagnosed or suspected health condition or disability. In most cases the physical health problem or disability will be documented in medical records. However, there may be instances in which a physical health problem is suspected but there is no evidence of a problem in the medical records. If there is not a problem or disability, check "no" or "unknown" and go directly to the next section.

Section 10. Mental health problems must be documented in the psychological or psychiatric records. If the child has no mental health problems, check "no" or "unknown" and go directly to the next section.

Appendix 8.1. State of Texas Common Application for Placement of Children in Residential Care (cont'd)

Part B — Behavior Rating Scale

The Behavior Rating Scale serves two primary functions. First, it presents a broad description of the child's behavior and general characteristics. Second, it helps to estimate the "Level of Care" at which the child should be placed.

Gather and review most or all of the information required to complete the Referral/Admissions Packet before filling out the Behavior Rating Scale. Take advantage of all available sources of information, including personal experience, interviews, and case records.

Scoring the Behavior Rating Scale Items

The Behavior Rating Scale items are scored using the following six rating scales:

1. Indicate the frequency of behavior within the last 6 months (Items 1 — 26):
   0 = None   1 = 1 or 2   2 = 3 or more
2. How typical is each item of the child's behavior? (Items 27 — 55).
   0 = Not At All Typical   1 = Somewhat Typical   2 = Very Typical
3. Indicate severity of child's current problem (Items 56 — 60):
   0 = None   1 = Mild/Moderate   2 = Severe
4. Indicate the child's current age group (Item 61):
   0 = 5 or Younger   1 = 6 to 10   2 = 11 or older
5. Indicate the number of specified incidents (Items 62 — 63):
   0 = none   1 = 1 Incident   2 = 2 or more incidents
6. Indicate yes or no (Item 64):
   0 = No   2 = Yes

Items 1 — 26 represent behaviors that are problems even if they occur only occasionally. For example, a child who physically assaults peers (Item 1) presents a problem even though such aggression may occur only once a month. These behaviors are fairly striking and your judgments will involve asking "How often did this behavior occur within the past six months: Not at all, once or twice, or more?"

Items 27 — 55 represent behaviors that are problems only if they occur too frequently or are characteristic of the child in general. For example, not being able to concentrate (Item 34) is a problem only if it represents a general characteristic of the child. Lapses in concentration that are normal for the child's age do not present a problem. However, a child who has much more difficulty concentrating than do other children of the same age has a real problem. When scoring items 27—55, you should ask yourself, "How typical of this child is this behavior?" One or two instances of a behavior are not sufficient to rate the behavior as typical. In general, it will not be difficult to decide on the score for a particular item. If you think of the child and your first reaction is, "Yes, that describes him," or "Yes, he does that all the time," then the behavior is very typical of the child. By the same token, if you have trouble thinking of instances when the child acted as described in the item, clearly the behavior is not at all typical of the child. The middle ground is when your reaction is, "Well, he does that but I would not describe the behavior as a strong characteristic. That is, he does act that way, but not often."

Items 56 — 60 are scored on the basis of the degree of the problem. In general, these problems should not be rated s severe unless there is documentation in medical, psychological, or educational records. The rating on Item 60, current severity of substance abuse, will be the highest current degree of abuse of alcohol, drugs, and/or inhalants. For example, if a child has a history of severe inhalant abuse but has replaced inhalants with alcohol and is abusing alcohol moderately, the item is scored "1" (mild/moderate) even though two substances are being abused. Since this item involves only current substance abuse, do NOT use information from the Screening Profile, which reflects the child's entire history of substance abuse.

Item 61 (age group): Do not round off the child's age. For example, a child who is five years and 10 months old is in the five or younger group.

Items 62 — 63 are scored based on the number of prior placements in licensed residential treatment centers (Item 62), and the number of adjudications for delinquent acts (Item 63). Item 62 can be completed from the information in Section 4 (page 9) of the Referral/Admissions Packet. Item 63 can be completed from Section 3 (pages 7 and 8) of the Referral Admissions Packet. For Item 63, the number of adjudications does not include CINS offenses.

Item 64 is scored yes only if a specialized residential placement is indicated in the psychological or psychiatric records.

Determining the Estimated Level of Care:

The first step in establishing a level of care for a child is to obtain the Estimated Level of Care. The Estimated Level of Care provides a guideline for selecting a specific, ideal level of care at which the agency believes the child should be placed.

The next step involves identifying the specific level of care to recommend for the child. The "Definitions of Level of Care" contains detailed descriptions of the six levels of care and should be consulted for guidance in distinguishing between Levels of Care 2 and 3, and Levels of Care 4, 5, and 6. In addition, special needs the child may have that are not reflected in the Estimated Level of Care may affect the final selection of the Recommended Level of Care. The Recommended Level of Care selected should be within the Estimated Level of Care guidelines unless there is a compelling reason for an exception. When an exception occurs, an explanation must be attached following page 4.

When the Billing Level of Care is established. enter it on page 1 of the Screening Profile.

Appendix 8.1. State of Texas Common Application for Placement of Children in Residential Care (cont'd)

Part C — Referral/Admissions Packet

The Referral/Admissions Packet is the key to the Common Application. It contains all of the information available regarding the child's history, problems, needs and goals. In order for the Common Application to serve the purpose for which it is intended, the information available must be organized. This is what the Referral/Admissions Packet does. It is important that all attachments be placed in the proper section so that care providers can readily locate the specific information they need to make decisions on accepting a child and appropriate program placement. For example, a medical report would be placed immediately following "Section 10 — Physical Health/Disabilities" (page 16), rather than being attached at the back of the the Referral/Admissions Packet.

1. **Social and Developmental Assessment** provides a description on the child's general social and developmental history. This section includes a description of the circumstances leading to referral, the immediate and long-range goals of placement, the child's relationships with others, the child's behavior, the child's developmental history, and the child's current level of functioning.

2. **Special Needs, Problems and Behavior** provides information relating to suicide history, assaultive behavior, running away, setting fires, and any other special needs not described in the other sections of the Referral/Admissions Packet.

3. **Juvenile Justice History** provides a detailed record of the child's referrals and dispositions. It provides a description of the child's history of delinquency and the circumstances and specifics of the most recent adjudicated offense. Place all of the child's court orders involving the juvenile justice system immediately following page 8.

4. **Placement History** provides a complete chronological list of all of the child's placements since first out-of-home placement. Include both long-term and stopover placements such as emergency shelters, detention, TYC Reception Center, informal placements with relatives, and return(s) to home. (Note that stopover placements will not be included in the Screening Profile.) Start with the child's first out-of-home placement and list all placements in order. Use as many pages as necessary. Number the pages in the upper right hand corner by completing "Page ____ of ____." This way when a new placement occurs it is simply added to Section 6 and the form does not have to be retyped.

5. **Substance Abuse History** provides information on the child's history of substance use, abuse, manufacture, possession, and/or delivery. It provides similar information for the child's extended family. Any treatment for substance abuse and the outcome is described.

6. **History of Abuse/Neglect of Referred Child** provides a description of the abuse or neglect experienced by the child. The role of the parent/perpetrator is described as is the extent of harm to the child.

7. **Family History** contains information on persons outside the home, characteristics of family members, strengths and weaknesses in the child's relationships with family and significant others, and the overall family situation.

8. **Financial Information** provides specific information regarding employment for the responsible male and female, Medicaid, and other funds available to the child.

9. **Education** contains the most recent IEP, ARD committee report, a transcript, and information on the child's adaptive behavior level. It provides a description of any educational problems, needs, or behaviors not included in the educational records. Place all attachments immediately following page 16.

10. **Physical Health/Disabilities** contains the child's medical and dental records. It provides a description of any physical health problem or disability not contained in those records. Place the specified attachments immediately following page 16.

11. **Mental Health** contains the child's psychological and psychiatric reports, if any. It also provides a description of any mental health problems not included in those records. Place the specified attachments immediately following page 17.

12. **Other Attachments** contains the child's birth certificate or other birth verification, legal records not specifically included elsewhere, the authorization forms used by the placing agency, and any other documents deemed relevant and not included in other sections of the Referral/Admissions Packet.

Appendix 8.1. State of Texas Common Application for Placement of Children in Residential Care (cont'd)

A. Screening Profile

Child's Name				Date of Birth Age	Social Security Number
Sex ☐ M ☐ F	Ethnicity	Primary Language		Country of Citizenship	Child's Agency ID Number
Height	Weight	Religious Preference	Billing Loc	Child's Current Location or Placement	

1. Briefly describe your impressions of the child including present problems:

____

____

____

Briefly describe the child's strengths:

____

____

____

2. Special Needs, Programs and Behaviors

Is child considered a danger to self? ☐ Yes ☐ No	Is child considered a danger to others? ☐ Yes ☐ No	Number runaways from home: ♦	Number runaways from placement: ♦
Any history of setting fires? ☐ Yes ☐ No	Special Program Needs? ☐ Maternity ☐ Preparation for Adult living ☐ Other: ♦ Specify:		
Other Significant Problems or Behaviors			

3. Juvenile Justice History

Does the child have a history of involvement with the Juvenile Justice System? .... ☐ Yes ☐ No ☐ Unknown

If yes: Number of referrals to juvenile authorities: ♦	Number of adjudications for delinquent acts: ♦	Number of adjudications for CINS offenses: ♦

4. Placement History

Has the child been placed away from home before? Do not include stopover placements such as emergency shelters, detention, TYC Reception Center, informal placements with relatives, or return(s) to home. .... ☐ Yes ☐ No ☐ Unknown

If yes: Number of previous out-of-home placements: ♦	Number of failed adoption placements: ♦	LOC of current/most recent out-of-home placement: ♦
Date of discharge from most recent out-of-home placement: ♦		

Reason for Discharge: ______________________________

____

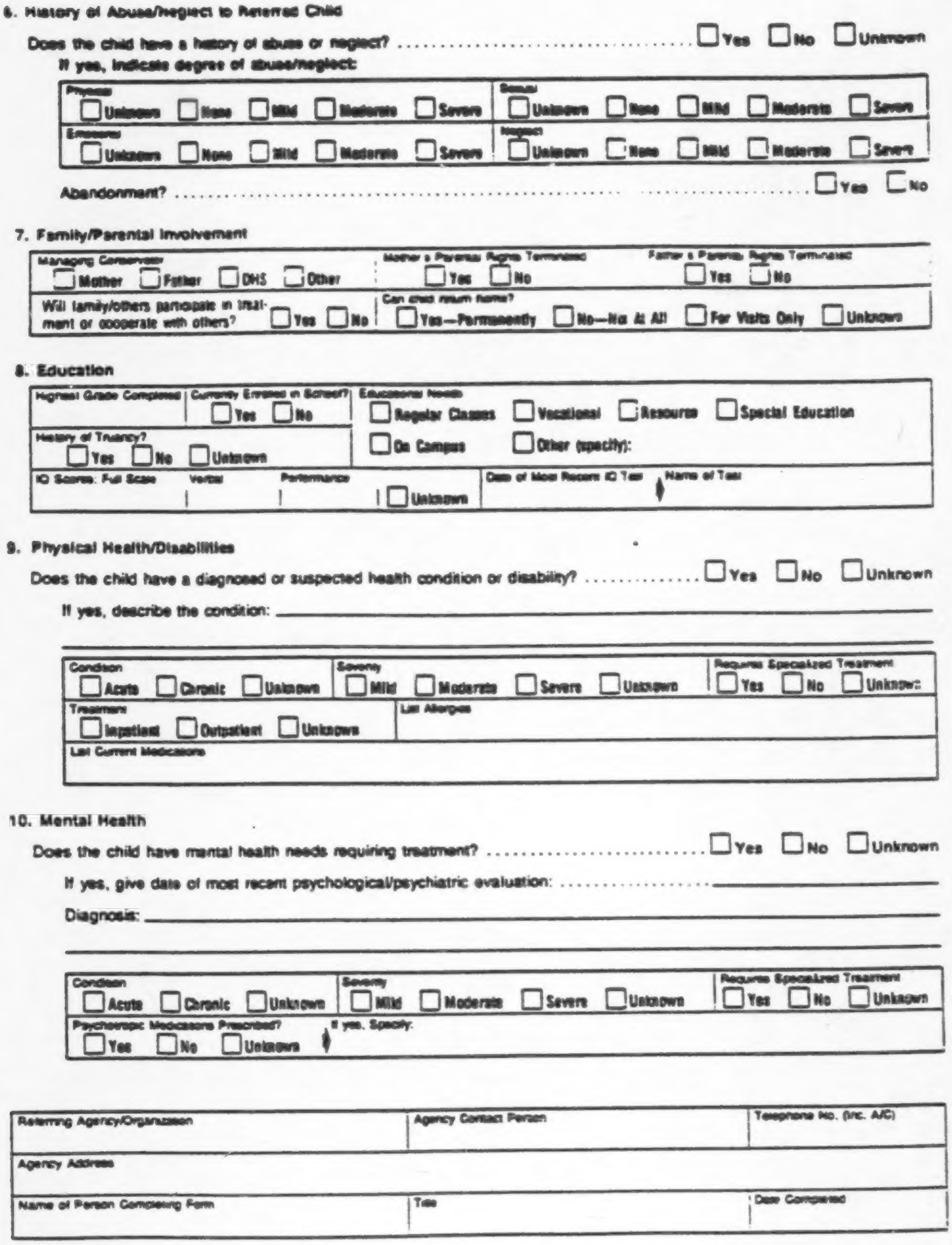
5. Substance Abuse History

Does the child have a history of substance abuse? .... ☐ Yes ☐ No ☐ Unknown

If yes, indicate degree of substance abuse:

Alcohol ☐ Unknown ☐ None ☐ Mild ☐ Moderate ☐ Severe	Inhalants ☐ Unknown ☐ None ☐ Mild ☐ Moderate ☐ Severe
Marijuana ☐ Unknown ☐ None ☐ Mild ☐ Moderate ☐ Severe	Cocaine/Crack ☐ Unknown ☐ None ☐ Mild ☐ Moderate ☐ Severe
Other Drugs (Specify) ♦ ☐ Mild ☐ Moderate ☐ Severe	
Is specialized Program Required? ☐ Yes ☐ No ☐ Unknown ♦ If Yes, Specify.	

Appendix 8.1. State of Texas Common Application for Placement of Children in Residential Care (cont'd)



6. History of Abuse/Neglect to Referred Child

Does the child have a history of abuse or neglect? .... ☐ Yes ☐ No ☐ Unknown

If yes, indicate degree of abuse/neglect:

Physical ☐ Unknown ☐ None ☐ Mild ☐ Moderate ☐ Severe	Sexual ☐ Unknown ☐ None ☐ Mild ☐ Moderate ☐ Severe
Emotional ☐ Unknown ☐ None ☐ Mild ☐ Moderate ☐ Severe	Neglect ☐ Unknown ☐ None ☐ Mild ☐ Moderate ☐ Severe

Abandonment? .... ☐ Yes ☐ No

7. Family/Parental Involvement

Managing Conservator ☐ Mother ☐ Father ☐ DHS ☐ Other	Mother's Parental Rights Terminated ☐ Yes ☐ No	Father's Parental Rights Terminated ☐ Yes ☐ No
Will family/others participate in treatment or cooperate with others? ☐ Yes ☐ No	Can child return home? ☐ Yes—Permanently ☐ No—Not At All ☐ For Visits Only ☐ Unknown	

8. Education

Highest Grade Completed	Currently Enrolled in School? ☐ Yes ☐ No	Educational Needs ☐ Regular Classes ☐ Vocational ☐ Resource ☐ Special Education ☐ On Campus ☐ Other (specify):	
History of Truancy? ☐ Yes ☐ No ☐ Unknown			
IQ Scores: Full Scale	Verbal	Performance ☐ Unknown	Date of Most Recent IQ Test / Name of Test

9. Physical Health/Disabilities

Does the child have a diagnosed or suspected health condition or disability? .... ☐ Yes ☐ No ☐ Unknown

If yes, describe the condition: ______________________________

Condition ☐ Acute ☐ Chronic ☐ Unknown	Severity ☐ Mild ☐ Moderate ☐ Severe ☐ Unknown	Requires Specialized Treatment ☐ Yes ☐ No ☐ Unknown
Treatment ☐ Inpatient ☐ Outpatient ☐ Unknown	List Allergies	
List Current Medications		

10. Mental Health

Does the child have mental health needs requiring treatment? .... ☐ Yes ☐ No ☐ Unknown

If yes, give date of most recent psychological/psychiatric evaluation: .... ______________

Diagnosis: ______________________________

Condition ☐ Acute ☐ Chronic ☐ Unknown	Severity ☐ Mild ☐ Moderate ☐ Severe ☐ Unknown	Requires Specialized Treatment ☐ Yes ☐ No ☐ Unknown
Psychotropic Medications Prescribed? ☐ Yes ☐ No ☐ Unknown	If yes, Specify:	

Referring Agency/Organization	Agency Contact Person	Telephone No. (inc. A/C)
Agency Address		
Name of Person Completing Form	Title	Date Completed

Appendix 8.1. State of Texas Common Application for Placement of Children in Residential Care (cont'd)

E. Behavior Rating Scale

Child's Name

Case No

Date

	FREQUENCY OF BEHAVIOR WITHIN PAST SIX MONTHS		
	0	1 or 2	3 or more
1. Physically assaults peers	0	1	2
2. Physically assaults adults	0	1	2
3 Verbally or physically threatens people	0	1	2
4. Is cruel to animals	0	1	2
5. Is cruel, bullying or mean to others	0	1	2
6. Talks about killing self	0	1	2
7. Deliberately harms self or attempts suicide	0	1	2
8. Damages or destroys own possessions	0	1	2
9. Damages or destroys possessions of others	0	1	2
10: Vandalizes	0	1	2
11. Sets fires	0	1	2
12. Has documented problems with school work	0	1	2
13. Is truant, skips school	0	1	2
14. Runs away from home	0	1	2
15. Behaves like opposite sex	0	1	2
16. Has sexual problems	0	1	2
17. Steals at home	0	1	2
18. Steals outside the home	0	1	2
19. Exhibits strange or bizarre behavior	0	1	2
20. Eats or drinks things that are not food	0	1	2
21. Plays with own sex parts in public	0	1	2
22. Hallucinates	0	1	2
23. Wets self during the day	0	1	2
24. Wets the bed	0	1	2
25. Has bowel movements outside the toilet	0	1	2
26. Smears or plays with bowel movements	0	1	2

	HOW TYPICAL OF CHILD'S BEHAVIOR		
	Not At All	Some-what	Very
27. Does not appear to feel guilty after misbehaving	0	1	2
28. Expresses feeling that others are out to get him/her	0	1	2
29. Lies and/or cheats	0	1	2
30. Has quit speaking	0	1	2
31. Wishes to be the opposite sex	0	1	2
32. Withdraws, does not get involved with others	0	1	2
33. Worries excessively, preoccupied with minor annoyances	0	1	2
34. Can't concentrate, is easily distracted	0	1	2

Appendix 8.1. State of Texas Common Application for Placement of Children in Residential Care (cont'd)

Child's name	Client No	Date

	OF CHILD'S BEHAVIOR		
	Not At All	Some-what	Very
35. Does not get along with other children	0	1	2
36. Expresses feelings of worthlessness or inferiority	0	1	2
37. Prefers playing with older children	0	1	2
38. Stares blankly	0	1	2
39. Sulks, pouts, whines	0	1	2
40. Acts fearfully or anxiously	0	1	2
41. Has trouble sleeping	0	1	2
42. Is underactive, slow moving, or lacks energy	0	1	2
43. Is sad, unhappy, or depressed	0	1	2
44. Screams	0	1	2
45. Cries more or less than usual for age	0	1	2
46. Demands attention	0	1	2
47. Can't sit still, is restless or hyperactive	0	1	2
48. Acts disobediently at home	0	1	2
49. Acts disobediently at school	0	1	2
50. Gets into fights	0	1	2
51. Associates with children who get into trouble	0	1	2
52. Swears, uses obscene language	0	1	2
53. Has temper tantrums, is volatile	0	1	2
54. Is impulsive, acts without thinking	0	1	2
55. Exhibits sudden mood changes	0	1	2

	SEVERITY OF CHILD'S CURRENT PROBLEM		
	None	Mild/ Moderate	Severe
56. Speech Problems	0	1	2
57. Allergies	0	1	2
58. Asthma	0	1	2
59. Overweight or underweight	0	1	2
60. Substance abuse (drugs, alcohol, inhalants)	0	1	2

61. Age Group	☐ 0 (5 or younger)	☐ 1 (6 to 10)	☐ 2 (11 or older)
62. Number of Prior placements in licensed residential treatment centers:	☐ 0 (none)	☐ 1 (one)	☐ 2 (2 or more)
63. Number of adjudications for delinquent acts (do not include CINS offenses):	☐ 0 (none)	☐ 1 (one)	☐ 2 (2 or more)
64. Mental health problem requires a specialized residential placement:	☐ 0 (No)		☐ 2 (Yes)

TOTAL SCORE ____________

Estimated LOC ____________

Recommended LOC ____________

If the Billing Level of Care is different from the Estimated Level of Care, attach an explanation. Billing LOC ____________

Appendix 8.1. State of Texas Common Application for Placement of Children in Residential Care (cont'd)

CONTENTS

SECTION 1—Social and Developmental Assessment
SECTION 2—Special Needs, Problems, and Behavior
SECTION 3—Juvenile Justice History
SECTION 4—Placement History
SECTION 5—Substance Abuse History
SECTION 6—History of Abuse/Neglect
SECTION 7—Family History
SECTION 8—Financial Information
SECTION 9—Education
SECTION 10—Physical Health/Disabilities
SECTION 11—Mental Health
SECTION 12—Other Attachments

SECTION 1—Social and Developmental Assessment

Describe the child's general social and developmental history. Feel free to expand the description of your impressions of the child. Be certain that you include all of the following:

A. A description of the circumstances that led to the child's referral

____

____

____

____

B. The immediate and long range goals of placement

____

____

____

____

C. A description of the child's relationship with other significant adults and children.

____

____

____

____

D. A description of the child's behavior including both appropriate and inappropriate behavior.

____

____

____

E. The child's developmental history and current level of functioning.

____

____

____

Appendix 8.1. State of Texas Common Application for Placement of Children in Residential Care (cont'd)

SECTION 2—Special Needs, Problems and Behaviors

Describe in detail the special needs, problems, or behaviors identified in Section 2 of the Screening Profile.

A. Suicide History. Describe suicide attempts and gestures in detail. Include the number of suicide attempts, and the date of the last known suicide attempt.

B. History of child's assaultive behavior.

C. Runaway history.

D. Other significant needs, problems and behaviors (including setting fires, maternity, etc.).

Appendix 8.1. State of Texas Common Application for Placement of Children in Residential Care (cont'd)

SECTION 3 — Juvenile Justice History

REFERRALS (list only one referral per date)				DISPOSITIONS (list only one disposition per date)				
Date	Offense	Level*	Penal Code	Type**	Date	Offense	Level* (list only if different from referral)	Penal C

Total Number of Referrals:	◆
Total Number of Adjudications/ Certifications (AP, AT, or CA)	◆

*LEVEL OF OFFENSE CODES:

FL = Felony
MI = Misdemeanor
FC = Family Code

**TYPE OF DISPOSITION CODES:

CR = Counseled and Released	RD = Refused/Dismis
IA = Informal Adjustment	AT = Adjudicated to T
AP = Adjudicated to Probation	CA = Certified as Ad

Appendix 8.1. State of Texas Common Application for Placement of Children in Residential Care (cont'd)

Briefly describe the child's history of delinquency. Include a description of contributing factors, whether the child is a follower or a leader, and delinquency patterns you detect.

Describe the most recent criminal episode, contributing factors, the child's actions or role in the episode, and how this episode fits into the child's history of delinquency.

Attach all court orders involving the juvenile system.

Appendix 8.1. State of Texas Common Application for Placement of Children in Residential Care (cont'd)

Section 4—Placement History (DHS Form 2223 may be substituted for this page.)

Start with the child's first out-of-home placement:

Date Placed	Name of Facility or Living Arrangement	License Type
Address	Contact Person	Telephone No.
Date Placement Ended	Reason Placement Ended	
LOC and dates Assigned	Continued Contact of Child with Placement Recommended ☐ Yes ☐ No ☐ Unknown	

Date Placed	Name of Facility or Living Arrangement	License Type
Address	Contact Person	Telephone No.
Date Placement Ended	Reason Placement Ended	
LOC and dates Assigned	Continued Contact of Child with Placement Recommended ☐ Yes ☐ No ☐ Unknown	

Date Placed	Name of Facility or Living Arrangement	License Type
Address	Contact Person	Telephone No.
Date Placement Ended	Reason Placement Ended	
LOC and dates Assigned	Continued Contact of Child with Placement Recommended ☐ Yes ☐ No ☐ Unknown	

Date Placed	Name of Facility or Living Arrangement	License Type
Address	Contact Person	Telephone No.
Date Placement Ended	Reason Placement Ended	
LOC and dates Assigned	Continued Contact of Child with Placement Recommended ☐ Yes ☐ No ☐ Unknown	

Date Placed	Name of Facility or Living Arrangement	License Type
Address	Contact Person	Telephone No.
Date Placement Ended	Reason Placement Ended	
LOC and dates Assigned	Continued Contact of Child with Placement Recommended ☐ Yes ☐ No ☐ Unknown	

Date Placed	Name of Facility or Living Arrangement	License Type
Address	Contact Person	Telephone No.
Date Placement Ended	Reason Placement Ended	
LOC and dates Assigned	Continued Contact of Child with Placement Recommended ☐ Yes ☐ No ☐ Unknown	

Page _____ of _____

Appendix 8.1. State of Texas Common Application for Placement of Children in Residential Care (cont'd)

SECTION 5—Substance Abuse History

A. Describe the child's history of substance use, abuse, manufacture, possession, and/or delivery.

B. Describe the child's family history of substance use, abuse, manufacture, possession, and/or delivery. Include not only parents and siblings, but also extended family members, such as grandparents, aunts, uncles, etc., even if they do not live in the same household as the child.

C. Describe any treatment the child has received for substance abuse and the success or failure of this treatment. Include information such as the length and dates of treatment, whether the program was residential or outpatient, whether the child completed the program, whether the family was included in the treatment, etc.

Appendix 8.1. State of Texas Common Application for Placement of Children in Residential Care (cont'd)

SECTION 6—History of Abuse/Neglect (DHS Form 2204, page 4, may be substituted for this page.)

A. Type of Abuse/Neglect (check all that apply):

Abandonment ☐ Reason to Believe ☐ Legally Confirmed/Adjudicated	Neglectful Supervision ☐ Reason to Believe ☐ Legally Confirmed/Adjudicated
Medical Neglect ☐ Reason to Believe ☐ Legally Confirmed/Adjudicated	Physical Neglect ☐ Reason to Believe ☐ Legally Confirmed/Adjudicated
Emotional Abuse ☐ Reason to Believe ☐ Legally Confirmed/Adjudicated	Physical Abuse ☐ Reason to Believe ☐ Legally Confirmed/Adjudicated
Sexual Abuse ☐ Reason to Believe ☐ Legally Confirmed/Adjudicated	

B. What did the parent/perpetrator do? Summarize the role of each parent/perpetrator.

C. What happened to the child? Summarize the extent of harm (or the substantial risk of harm) to the child.

Appendix 8.1. State of Texas Common Application for Placement of Children in Residential Care (cont'd)

SECTION 7—Family History (DHS Form 2048, page 1, may be substituted for this page.)

Home Address (Street, City, State, Country, ZIP)	Telephone No. (inc. A/C)

Marital Status of Birth Parents
☐ Never Married ☐ Married ☐ Divorced ☐ Separated ☐ Widowed

Marital Status of Adoptive Parents
☐ Never Married ☐ Married ☐ Divorced ☐ Separated ☐ Widowed

Deaths in immediate family (list names, relationships, and age of referred child at the time of death)

If adopted, what does the child know about his or her birth parents?

Persons in Home

Father	Date of Birth*	Type of Parent ☐ Birth ☐ Adoptive ☐ Step	Social Security No.
Mother	Date of Birth*	Type of Parent ☐ Birth ☐ Adoptive ☐ Step	Social Security No.

BLOOD SIBLINGS	DATE OF BIRTH*

BLOOD SIBLINGS	DATE OF BIRTH*

OTHER CHILDREN	DATE OF BIRTH*	RELATIONSHIP/ROLE

OTHERS	DATE OF BIRTH*	RELATIONSHIP/ROLE

*Give approximate age if date of birth is unknown.

Appendix 8.1. State of Texas Common Application for Placement of Children in Residential Care (cont'd)

Significant Persons Out of Home (DHS Form 2046, page 2 and DHS Form 2206, page 2 may be substituted for this page.)

Father	Date of Birth*	Type of Parent ☐ Birth ☐ Adoptive ☐ Step	Social Security No.
Address (Street, City, State, County, ZIP)		Telephone No. (inc. A/C)	Currently Involved with Child ☐ Yes ☐ No
Mother	Date of Birth*	Type of Parent ☐ Birth ☐ Adoptive ☐ Step	Social Security No.
Address (Street, City, State, County, ZIP)		Telephone No. (inc. A/C)	Currently Involved with Child ☐ Yes ☐ No

OTHERS	DATE OF BIRTH*	RELATIONSHIP/ROLE

*Give approximate age if date of birth is unknown.

Characteristics of Individual Family Members with Whom Child has Lived:	NO	YES	FAMILY MEMBER(S)
1. Violent Toward Family Members			
2. Suicide			
3. Substance Abuse Problems			
4. Criminal Behavior			
5. Involving a Child in Criminal Behavior			
6. Mental Retardation or Limited Intellectual Ability			
7. Mental Illness or Disability			
8. Physical Illness or Disability			
9. Sexual Deviance			

Characteristics of the Family as a Whole with Whom Child has Lived:	Not At All Like Family	Somewhat/ Sometimes Like Family	Very Much or Often Like Family
1. Chronic Poverty			
2. Chaotic Home Environment			
3. Rigid, Inflexible			
4. Smothering; Individualization of Members is Discouraged			
5. Enmeshed; Few Outside Involvements			
6. Discipline Skills Lacking			

	Not At All Like Family	Somewhat/ Sometimes Like Family	Very Much or Often Like Family
7. Difficult or Unacceptable to Express Emotions			
8. Frequent Family Moves or School Moves			
9. Child Moved from One Parent or Family Member to Another			
10. Concern with Psychosomatic Complaints			
11. Social Isolation			
12. Illiteracy			

Appendix 8.1. State of Texas Common Application for Placement of Children [illegible] Residential Care (cont'd)

Briefly describe the child's relationships with family members and significant others, both in and out of the home. Address both strengths and weaknesses.

Briefly describe the overall family situation, highlighting the positive and negative aspects of the child's family environment including all the "Family Characteristics" checked affirmatively on page 13.

Other significant information:

Appendix 8.1. State of Texas Common Application for Placement of Children in Residential Care (cont'd)

SECTION 8—Financial Information

Name of Responsible Male	Disabled? ☐ Yes ☐ No	Occupation

Employer	Salary $ per
Employer's Address	

Other Income Source (1)	Amount $	Other Income Source (2)	Amount $

Name of Responsible Female	Disabled? ☐ Yes ☐ No	Occupation

Employer	Salary $ per
Employer's Address	

Other Income Source (1)	Amount $	Other Income Source (2)	Amount $

Is the family eligible for Medicaid? .... ☐ Yes ☐ No ☐ Unknown

Is the family currently receiving Medicaid? .... ☐ Yes ☐ No ☐ Unknown

Funds Applicable to Child:

VA — Amount $	VA No.	Received By		
Social Security — Amount $	Social Security No.	Received By		
CHAMPUS — Amount $	CHAMPUS I.D. No.	Received By		
AFDC/SPFC — Amount $	County Paid FC — Amount $	Child Support — Amount $	Paid By	County

Insurance Applicable to Child:

Insurance Company Name (1)	Policy Holder	Policy No.
Insurance Company Name (2)	Policy Holder	Policy No.
Insurance Company Name (3)	Policy Holder	Policy No.

Type of Insurance
☐ Basic Medical ☐ Hospitalization ☐ Basic Dental ☐ Orthodontic ☐ Mental Health

Other Resources Applicable to Child:

Appendix 8.1. State of Texas Common Application for Placement of Children in Residential Care (cont'd)

SECTION 11—Mental Health

Attach (as appropriate):
- A. Psychological Report(s)
- B. Psychiatric Report(s)

Describe any mental health problems not otherwise documented. Add any additional information you feel is important.

SECTION 12—Other Attachments

Attach:
- A. Birth Certificate or Other Birth Verification
- B. Legal Records (if any)
- C. Authorization Forms

Appendix 8.2. Residential Care Cost Analysis Questionnaire

SERVICE NEEDS OF CHILD

LEVEL I
(core standard)

1. **Provides a family oriented setting that meets the basic need of the child and ensures emotional and physical well-being.**

Indicators:

Meets Department of Human Services (DHS) Licensing requirements or Texas Youth Commission (TYC) standards.

LEVEL II
(additional standards)

1. **Provides services designed to improve the child's functioning.**

Indicators:

Clear rules that are appropriate for developmental levels of children.

Clear system of rewards and consequences.

Organized activities in the family unit; i.e., games, family conferences.

Activities in the community; i.e., school, church, and community social events.

LEVEL III
(additional standards)

1. **Provides structure and a higher level of supervision.**

Indicators:

Case work services must be available on a regularly scheduled basis to the children specified in each child's treatment plan.

Supervisory/casework services must be available to the direct caregivers to support and direct parenting efforts.

MEDICAL CARE

LEVEL I
(core standard)

1. **Arrangement of routine medical and dental services is determined through an agreement between caregivers and the placing agency.**

Indicators:

Meets Department of Human Services (DHS) Licensing requirements or Texas Youth Commission (TYC) standards.

LEVEL II
(additional standards)

1. **Arrangement of routine medical and dental services is determined through an agreement between caregiver and the placing agency.**

Indicators:

Provides transportation to medical and dental appointments as reflected in medical records.

LEVEL III
(additional standards)

1. **Arrangement of routine medical and dental services is determined through and agreement between caregiver and the placing agency.**

Indicators:

Same as Level II

Appendix 8.2. Residential Care Cost Analysis Questionnaire (cont'd)

RECREATIONAL ACTIVITIES AND LEISURE TIME

LEVEL I
(core standards)

1. **Provides routine parental supervision, recreation and leisure time activities.**

Indicators:

Meets Department of Human Services (DHS) Licensing requirements or Texas Youth Commission (TYC) standards.

LEVEL II
(additional standards)

1. **Provides structured recreational activities and leisure time activities.**

Indicators:

Provides structured activities and leisure time for children in the home.

LEVEL III
(additional standards)

1. **Provides structured and supervised recreational activities.**

Indicators:

Written plans for activities which indicate kinds and frequency along with kind of staff involvement and supervision.

2. **Provides structured daily routine and leisure time activities.**

Indicators:

Written plans for daily routine and leisure time.

Appendix 8.2. Residential Care Cost Analysis Questionnaire (cont'd)

EDUCATION

LEVEL I **(core standard)**	**1. Provides access to free, appropriate public education and related services through the local public school district and within guidelines set by state and federal law.** Indicators: Meets Department of Human Services (DHS) Licensing requirements or Texas Youth Commission (TYC) standards.
LEVEL II	**1. Provides access to free, appropriate public education and related services through the local public school district and within guidelines set by state and federal law.** Indicators: Same as Level I.
LEVEL III	**1. Provides access to free, appropriate public education and related services through the local public school district and within guidelines set by state and federal law.** Indicators: Additional education support is made available through formal liaison with schools.

Appendix 8.2. Residential Care Cost Analysis Questionnaire (cont'd)

THERAPEUTIC INTERVENTIONS AND CASE MANAGEMENT

LEVEL I
(core standard)

1. **Provides consistency, reassurance and regular parenting and activities designed to develop normalized social skills.**

Indicators:

Meets Department of Human Services (DHS) Licensing requirements or Texas Youth Commission (TYC) standards.

Monthly contacts are required between the placing agency and caregiver.

LEVEL II
(additional standards)

1. **Provides therapeutic interventions within the milieu designed to improve the child's functioning.**

Indicators:

Individualized programming must be provided as reflected in the written plan of service.

Fifteen hours of training as designated by Licensing/Certification/approving agency required annually for each caregiver.

LEVEL III

1. **Provides therapeutic intervention within the milieu designed to improve the child's functioning. Formalized behavioral programs and therapeutic interventions are implemented by professional or paraprofessional staff under the direct supervision of professional staff.**

Indicators:

Differentiated programming based on needs of children in care.

Treatment modalities must be specified along with the level and qualification of staff who will provide and supervise treatment.

A caseworker is required on staff.

Administrative, casework and clinical supervisory staff must have a minimum of one (1) year experience in out-of-home services to children.

Written structured daily routines must be developed.

Staff who develop and supervise behavioral programs and therapeutic interventions must be one of the following: (1) psychiatrist - a licensed physician with advanced training in the diagnosis and treatment of mental and emotional disorders; (2) psychologist - a person qualified according to the Psychologists' Certification and Licensing Act; (3) social worker - a person certified by DHS as a certified social worker; or a person with a master's degree from an accredited college or university; or (4) professional counselors licensed by the Texas Department of Health. Other professional staff in fields such as nursing, special education, or vocational counseling may be included in the professional staffing plan if their responsibilities are appropriate to the scope of the facility's program description. The professionals must have the minimum qualifications generally recognized in their area of specialization.

Each direct caregiver is required to have 30 hours of training annually as designated by the Licensing/certification/approving agency in the facility's treatment methods, programs, and behavior management, and general characteristics of client group(s) served.

Appendix 8.2. Residential Care Cost Analysis Questionnaire (cont'd)

STAFF RATIO

LEVEL I
(core standards)

1. **Provides staff-to-child ratio as governed by licensing, certification, or monitoring standards.**

Indicators:

Meets Department of Human Services (DHS) Licensing Requirements or Texas Youth Commission (TYC) standards.

a. During waking hours staff ratio is one (1) to eight (8) for age five (5) and over; and one (1) to four (4) for children younger than five (5).

b. During sleeping hours, if staff are awake, the ratio is one (1) to twenty-four (24). If staff are asleep, the ratio is one (1) to sixteen (16).

c. For halfway-houses, the staff ratio during awake hours is one (1) to ten (10); and during sleeping hours the ratio is one (1) to sixteen (16).

d. For therapeutic camps the staff ratio during awake hours is one (1) to six (6) and during sleeping hours is one (1) to twelve (12).

LEVEL II
(additional standards)

1. **Provides staff-to-child ratio as governed by licensing, certification, or monitoring standards.**

Indicators:

Same as Level I.

LEVEL III
(additional standards)

1. **Provides staff-to-child ratio as governed by licensing, certification, or monitoring standards.**

Indicators:

Same as Level II.

SERVICE NEEDS OF THE CHILD

LEVEL IV
(core standards)

1. **Provides physical environment in which most activities are therapeutically designed to meet the social, emotional, and educational needs of each child.**

Indicators:

Meets Department of Human Services (DHS) Licensing requirements for residential treatment facilities or wilderness (therapeutic) camps or the Texas Commission on Alcohol and Drug Abuse (TCADA) licensing requirements for residential adolescent services.

Plans developed for direct, continuous observation if a child is accepted who presents a low to moderate risk of suicide or physical injury.

LEVEL V

1. **Provides a highly structured program to improve functions or maintenance of children with severe emotional or behavior disorders with moderate to severe risk of causing harm.**

Indicators:

Written description of program components showing interrelationship of service elements designed to meet treatment needs of level five (5) children.

Appendix 8.2. Residential Care Cost Analysis Questionnaire (cont'd)

MEDICAL CARE

LEVEL IV
(core standard)

1. **Arrangement of routine medical and dental services is determined through an agreement between caregiver and the placing agency.**

Indicators:

Same as Level II.

2. **Provides routine medical care and monitors chronic but stable physical illness through contractual agreements between the caregiver and physicians.**

Indicators:

Copy of plan, agreement, or contract agreement between the service provider and a licensed physician.

3. **Training must be received by individuals administering psychotropic medications in potential side effects and drug identification.**

Indicators:

The person conducting the training must be a physician, registered nurse, or pharmacist.

Upon completion of the medication training, each participant is assessed by the trainers to ensure mastery of course content.

The training course provided to direct care staff must include basic pharmacology (actions, side effect, adverse reactions), techniques and methods of administration of medication, policies and procedures.

4. **Provides monitoring by a psychiatrist monthly of children and adolescents receiving psychotropic medications.**

Indicators:

Copy of plan, agreement, or contract with a board eligible psychiatrist for the purpose of monitoring psychotropic medications monthly.

LEVEL V
(additional standards)

1. **Provide on-call medical, psychiatric and nursing services 24-hours a day for youth.**

Indicators:

Copy of plan, agreement, or contract to provide 24-hour on-call medical, nursing, and psychiatric services. Plan must include provisions for timely access to medical, nursing, and psychiatric services on campus in the event of an emergency. Weekly ro biweekly visits by a psychiatrist are required.

RECREATIONAL ACTIVITIES AND LEISURE TIME

LEVEL IV
(core standard)

1. **Provides therapeutically designed recreational activities and leisure time.**

Indicators:

Written description of recreational program and an explanation of how it fits in with the facility's therapeutic program.

LEVEL V
(additional standards)

1. **Provides recreation services through an individualized recreational plan designed by the inter-disciplinary team composed of professionals appropriate to the type of care.**

Indicators:

Copy of individualized treatment plan which includes recreational plans designed by the inter-disciplinary team.

EDUCATION

LEVEL IV
(core standard)

1. **Provides access to a free, appropriate public education and related services through the local public school district and within guidelines set by state and federal law.**

Indicators:

Written agreement or plan between service provider and school district (unless child is enrolled in school in usual way) to outline responsibilities of each party and address conflict resolution particularly if conflicts exist between the facility and the public school.

Accreditation by legally approved accreditation agency such as the Southern Association of Schools.

Texas Education Agency (TEA) approval of special education programs if not provided by school districts (for special education).

TEA approval of home taught programs.

LEVEL V
(additional standards)

1. **Provides access to a free, appropriate public education and related services through the local public school district and within guidelines set by state and federal law. To ensure 24-hour programmatic consistency, educational and related services will be coordinated with the child's treatment plan.**

Indicators:

On campus school or alternative education program must be available.

Documentation and coordination of consistency between the education plan and the treatment plan.

Appendix 8.2. Residential Care Cost Analysis Questionnaire (cont'd)

THERAPEUTIC INTERVENTIONS AND CASE MANAGEMENT

If licensed by Department of Human Services (DHS) a residential treatment--no further monitoring is required in this area.

LEVEL IV
(core standard)

1. **Provides therapeutic interventions within the milieu which are designed to improve the child's functioning.**

Indicators:

Meets TCADA licensing requirements for Residential Adolescent Services.

Overall program design with structured daily routine that reflects the treatment plan requirements.

A diagnostic assessment plan is developed for each child within 40 calendar days of admission. Assessment must include an evaluation of the child in the physical, familial, education, social, emotional/psychological, and behavioral areas.

A treatment plan is developed for each child within 40 calendar days of admission based on diagnostic assessment and includes: estimated length of stay, goals for treatment, specific instructions for staff, discharge plans, and indication that plan was shared with the child and child's parents or managing conservatorship and documents of treatment throughout stay.

The diagnostic assessment and treatment plan must be developed by either an inter-disciplinary team or a full-time staff person with at least the following minimum qualifications:

> A master's degree in a mental health field from an accredited college or university or certification by the department as a Certified Social Worker, and
>
> Three years of experience providing treatment services to emotionally disturbed persons; one year of this experience must have been in a residential setting.

Case work services are available to the child

2. **Provides additional training for both new and on-going staff relating to therapeutic treatment modalities, programming, and behavior management.**

Indicators:

New child care staff who have no previous experience working with children in a residential setting must have at least 40 hours of supervised child care experience in the facility before they are assigned as the only staff responsible for a group of children.

Until they have completed the supervised experience, an experienced child care staff must be physically available to the new staff at all times. Supervised child care experience must be documented.

Preservice training shall include management of aggressive behavior.

Each direct caregiver is required to have 50 hours approved training annually to include facility's treatment program and treatment process and behavioral management program. This training is in addition to any preservice training or the 40 hours supervised child care experience required.

3. **Formalized behavioral programs implemented by professional or paraprofessional staff under the direct supervision of professional staff.**

Indicators:

Behavioral program design with treatment modalities specified.

Initial treatment plan for each child is developed within 72 hours of admission.

Assessment intervention strategy is implemented for each child upon admission of that child.

4. **Planned interactions between professional staff and children, such as individual, group and family therapy.**

Indicators:

Meets TCADA licensing requirements for Residential Adolescent Services.

Written documentation verifying hours, type of interventions, proof of providing service, and treatment plan strategies.

Number of professional staff scheduled for formalized interaction (individual, group, and family).

The child care facility must have sufficient appropriately qualified professional staff available on a full-time, part-time, and/or continuing consultive basis to assess and address the needs of children in care.

The professional staffing plan must include a detailed description of the qualifications, duties, responsibilities, and authority of professional positions. For each position, the plan must show whether employment is on a full-time, part-time, or continuing consultive basis. For part-time and consulting positions, the number of hours and frequency of services must be specified.

The professional staffing plan must address responsibilities for diagnostic assessment, development and review of the plan, and provision of treatment services.

LEVEL V
(additional standards)

1. **Provides inter-disciplinary team composed of professionals which is required to develop, review, and supervise the treatment plans.**

Indicators:

Team membership reflects the ability to meet the child's individual needs as identified by the assessment and treatment plan.

Appendix 8.2. Residential Care Cost Analysis Questionnaire

STAFF RATIO

LEVEL IV
(core standards)

1. **Provides staff-to-child ratio as governed by licensing, certification or monitoring standards.**

Indicators:

Meets Department of Human Services (DHS) Licensing, Texas Youth Commission (TYC), Mental Health and Mental Retardation (MHMR) requirements or TCADA licensing requirements for Residential Adolescent Services.

Ability to provide awake night staff if indicated and based on the needs of the child.

LEVEL V
(additional standards)

1. **Provides awake night staff which is required for 24-hour supervision.**

Indicators:

Written staffing pattern/assignment which identifies staff-to-client ratio, hours of coverage, responsibilities, and qualifications.

During waking hours staff ratio for direct care staff is 1:5 and for Therapeutic Camps it is 1:6.

During sleep hours, there must be two (2) staff, one (1) of whom must be awake for every sixteen (16) children and for Therapeutic Camps the ability to provide awake night staff if indicated and based on the needs of the child.

Ability to provide 1:1 based on needs of child.

Appendix 8.2. Residential Care Cost Analysis Questionnaire

LEVEL VI

In order to provide services to children classified as level VI a facility must meet one of the following standards:

1. Mental Health and Mental Retardation (MHMR) Standards; or

2. Department of Human Services Minimum Standards for Institutions Serving M.R. Children with Primary Medical Needs; or

3. Department of Human Services Minimum Standards for Facilities Serving Children with Autistic-Like Behaviors; or

4. A facility licensed as residential treatment center and which meets standards for serving children classified as level V may provide services to children classified as level VI. This is based upon individual child agreements between the placing agency and child caring facility, and be paid at a level VI rate for a period of time not to exceed 90 days (subject to re-evaluation). The level V treatment plan must be expanded to include the following:

   a. Description of emotional/behavior/physical status that indicated a need for level VI services.

   b. Description of the goals the child must attain and maintain to achieve emotional/behavior/physical health necessary to no longer need level VI services.

   c. Description of the education and experiential level of staff specifically assigned to work with the child.

   e. Description of any new or unusual medical procedures and/or drug therapy indicated.

   f. Criteria for re-evaluating the need to continue level VI services beyond the initial period instead of transferring the child to a facility licensed under 1, 2, or 3 or as an in-patient hospital.

Appendix 8.3. Common Definitions for Residential Care

LEVEL I **Adequate functioning in all developmental and/or environmental areas. There may be transient difficulties, "every-day" worries, and occasional misbehavior, but would be regarded as a "normal" child; responds to "normal" discipline. The caregiver provides routine home environment with guidance and supervision to meet the needs of the child.**

A. SERVICE NEEDS OF THE CHILD

Children and adolescents at this level of care need an environment that provides maintenance and ensures emotional and physical well-being in a family oriented setting.

B. MEDICAL CARE

The provision of routine medical and dental services is the responsibilities of the child placing agency unless prohibited by state or federal law. In some instances, the cost of medical care may be the responsibility of the child's managing conservator. The role of the caregiver in the arrangement of these services is determined through agreement between the caregiver and the placing agency.

C. RECREATIONAL ACTIVITIES AND LEISURE TIME

The caregiver provides parenting supervision, recreation, and leisure time activities.

D. EDUCATION

Each child is provided access to a free, appropriate public education and related services through the local public school district and within guidelines set by state and federal law.

E. THERAPEUTIC INTERVENTIONS AND CASE MANAGEMENT

The caregiver provides consistency, reassurance, regular parenting and activities designed to develop normalized social skills.

The child placing agency is responsible for case management, and a minimum of one monthly contact with the caregiver.

F. STAFF RATIO

Staff-to-child ratio is governed by licensing, certification, or monitoring standards.

G. EXAMPLES OF CURRENT FACILITY OPERATIONS

Children at this level are typically served in DHS or TYC agency and independent foster family and foster group homes; Juvenile Court certified foster homes; DHS licensed basic care facilities.

LEVEL II **No more than occasional problems in functioning in any area, some acting-out behavior in response to life stresses, but these are brief and transient; minimally disturbing to others, and not considered deviant by those who know them. The caregiver provides routine home environment with supplemental guidance and discipline to meet the needs of the child.**

A. SERVICE NEEDS OF THE CHILD

Children and adolescents at this level of care needs services designed to improve the child(ren)'s functioning.

B. MEDICAL CARE

The provision of routine medical and dental services is the responsibility of the child placing agency unless prohibited by state or federal law. In some instances, the cost of medical care may the responsibility of the child's managing conservator. The role of the caregiver in the arrangement of these services is determined through agreement between the caregiver and the child placing agency.

C. RECREATIONAL ACTIVITIES AND LEISURE TIME

The caregiver is responsible for provision of structured recreational activities and leisure time.

D. EDUCATION

Each child is provided access to a free appropriate education through the local school district and within guidelines set by state and federal law.

E. THERAPEUTIC INTERVENTIONS AND CASE MANAGEMENT

The caregiver provides therapeutic intervention within the milieu designed to improve the child's functioning.

The child placing agency is responsible for case management, a minimum of one monthly contact with the caregiver, arrangement of diagnostic evaluations as needed, and arrangement for optional therapeutic intervention as needed. Option therapeutic interventions may include:

1. a formalized behavioral program implemented by professionals or paraprofessionals under the direct supervision of professionals, and
2. formalized interactions between professionals and children such as individual, group, or family therapy.

F. STAFF RATIO

Staff-to-child ratio is governed by licensing, certification or monitoring standards.

G. EXAMPLES OF CURRENT FACILITY OPERATIONS

Children at this level typically are served in DHS or TYC agency and independent foster family and foster group homes; Juvenile Court certified foster homes; DHS licensed basic care facilities.

Appendix 8.3. Common Definitions for Residential Care (cont'd)

LEVEL III **Frequent or repetitive minor problems in one or more areas; may engage in non-violent anti-social acts, but is capable of meaningful interpersonal relationships. Requires supervision in structured supportive setting with counseling available from professional or para-professional staff.**

A. SERVICE NEEDS OF THE CHILD

Children and adolescents at this level of care need structure, educational support, a higher level of supervision and the development of normalized social skills.

B. MEDICAL CARE

The provision of routine medical and dental services is the responsibility of the child-placing agency unless prohibited by state or federal law. In some instances, the cost of medical care my be the responsibility of the child's managing conservator. The role of the caregiver in the arrangement of these services is determined through agreement between the caregiver and the child placing agency.

C. RECREATIONAL ACTIVITIES AND LEISURE TIME

The caregiver provides a structured and supervised environment. Daily routine and leisure time activities are structured. The provision of these activities is the responsibility of the caregiver.

D. EDUCATION

Each child is provided access to a free, appropriate public education and related services through the local public school district and within guidelines set by state and federal law.

E. THERAPEUTIC INTERVENTIONS AND CASE MANAGEMENT

The caregiver provides therapeutic intervention within the milieu designed to improve the child's functioning. The caregiver provides formalized behavioral programs implemented by professional staff or paraprofessional staff under the direct supervision of professional staff.

The child placing agency is responsible for the provision of case management services, a minimum of one monthly contact with caregiver, the arrangement of diagnostic evaluations as needed. Optional therapeutic interventions may include individual, group, or family therapy.

F. STAFF RATIO

Staff-to-child ratio is governed by licensing, certification or monitoring standards.

G. EXAMPLES OF CURRENT FACILITY OPERATIONS

Children and adolescents at this level typically are served in DHS licensed therapeutic foster family and therapeutic foster group homes; TYC or Juvenile Court approved foster family and foster group homes which meet DHS licensing standards for therapeutic foster family or therapeutic foster group homes; DHS licensed basic care facilities; DHS licensed residential treatment centers; DHS licensed wilderness camps; DHS licensed half-way houses; DHS licensed programs serving mentally retarded children and adolescents; DHS habilitative foster family and foster group homes.

LEVEL IV **Substantial problems; have physical, mental, or social needs and behaviors that may present a moderate risk of causing harm to themselves or others, poor or inappropriate social skills, frequent episodes of aggressive or other antisocial behavior with some preservation or meaningful social relationships. Require treatment program in a structured supportive setting with therapeutic counseling available by professional staff.**

A. SERVICE NEEDS OF THE CHILD

Children and adolescents at this level of care have physical, mental, and emotional needs and behaviors that may present a low to moderate risk of causing harm to themselves or others. They require physical environments and treatment programs in which most activities are therapeutically designed to improve social, emotional and educational adaptive behavior. These children may require psychological or psychiatric services which are integrated into the residential program to assess and monitor admission, discharge, and treatment plans.

B. MEDICAL CARE

Provision of routine medical and dental services is the responsibility of the child placing agency unless prohibited by state or federal law. In some instances, the cost of medical care may be the responsibility of the child's managing conservator. The role of the caregiver in the arrangement of these services is determined through agreement between the child placing agency and the caregiver. The caregiver has contractual agreements with physicians to provide routine medical care and to monitor chronic but stable physical illness. Individuals administering psychotropic medications must receive training in potential side effects and drug identification. Children and adolescents receiving psychotropic medications are monitored by a psychiatrist monthly.

C. RECREATIONAL ACTIVITIES

The caregiver is responsible for the provision of therapeutically designed recreational activities and leisure time.

D. EDUCATION

Each child is provided access to a free, appropriate public education and related services through the local public school district and within guidelines set by state and federal law.

E. THERAPEUTIC INTERVENTION AND CASE MANAGEMENT

The caregiver provides therapeutic interventions within the milieu designed to improve the child's functioning. The caregiver provides formalized behavioral programs implemented by professional staff, and formalized interactions between professional staff and children, such as individual, group, and family therapy.

The child placing agency is responsible for the provision of case management services and a minimum of one monthly contact with the caregiver.

F. STAFF RATIO

Staff-to-child ratio is governed by licensing, certification or monitoring standards.

G. EXAMPLES OF CURRENT FACILITY OPERATIONS

Children and adolescents at this level typically are served in DHS licensed therapeutic foster family and therapeutic foster group homes; TYC or Juvenile Court approved foster family and foster group homes which meet DHS licensing standards for therapeutic foster family or therapeutic foster group homes; agency or independent foster family and foster group homes which meet DHS licensing standards for therapeutic foster family or therapeutic foster group homes; DHS licensed basic facilities; DHS licensed therapeutic camps; DHS licensed residential treatment centers; programs licensed by TCADA; DHS habilitative foster family and foster group homes, and DHS licensed programs serving mentally retarded children and adolescents.

LEVEL V **Severe problems, unable to function in multiple areas. Sometimes willing to cooperate when prompted or instructed, but may lack motivation or ability to participate in personal care or social activities or is severely impaired in reality testing or communications. May exhibit persistent or unpredictable aggression, be markedly withdrawn and isolated due to either mood or thought disturbance, or make suicidal attempts. Presents a moderate to server risk of causing harm to self or others. Requires 24-hour supervision by multiple staff in limited access setting.**

A. SERVICE NEEDS OF THE CHILD

Children and adolescents at this level of care have severe emotional or behavior disorders or conditions such that a highly structured program is essential to improved function or maintenance. They may present a moderate to severe risk of causing harm to themselves or others.

B. MEDICAL CARE

The caregiver provides access to appropriate laboratory and pharmacy services. Individuals administering psychotropic medications must receive training in potential side effects and drug identification.

All non-routine medical care which is unrelated to the emotional of behavioral problems for which the child is placed and all dental care are the financial responsibility of the child placing agency unless prohibited by state or federal law. In some instances, the cost of medical care may be the responsibility of the child's managing conservator.

C. RECREATIONAL ACTIVITIES AND LEISURE TIME

The caregiver provides recreational services through an individualized recreation plan designed by the inter-disciplinary team composed of professionals appropriate to the type of care.

D. EDUCATION

Every child is provided access to a free, appropriate public education and related services through the local public school district and within guidelines set by state and federal law. To ensure 24-hour programmatic consistency, educational and related services are coordinated with the child's treatment plan.

E. THERAPEUTIC INTERVENTIONS AND CASE MANAGEMENT

The caregiver provides therapeutic interventions within the milieu designed to improve the child's functioning. The caregiver provides formalized behavioral programs implemented by professional staff or paraprofessional staff under the direct supervision of professional staff, and formalized interactions between professional staff and children, such as individual, group, and family therapy. The treatment plan addresses all waking hours of the child's day. All activities planned and all interventions applied by the staff are individually designed with the goal of meeting the needs of, and correcting or minimizing the functional deficiencies of the child. Interdisciplinary teams composed of professionals appropriate to the type of care plan supervise the treatment programs for these children. In psychiatric facilities, the caregiver provides on-campus psychiatric consultation at admission, treatment reviews, discharge, and monthly medication reviews. The caregiver provides psychological testing as needed.

The child placing agency is responsible for the provision of case management services and a minimum of one monthly contact with the caregiver.

F. STAFF RATIO

Staff-to-child ratio is governed by licensing, certification or monitoring standards. Twenty-four hour supervision of children and adolescents is required.

G. EXAMPLES OF CURRENT FACILITY OPERATIONS

Children and adolescents at this level typically are served in a program which is licensed by DHS as a therapeutic camp or as a residential treatment center, in a program licensed by TCADA, or in a DHS licensed program serving mentally retarded children and adolescents.

Appendix 8.3. Common Definitions for Residential Care (cont'd)

LEVEL VI **Very severe impairment(s), disability(s) or need(s), consistently unable or unwilling to cooperate in own care. May be severely aggressive or exhibit self-destructive behavior or grossly impaired in reality testing, communication, cognition, affect or personal hygiene. May present severe to critical risk of causing serious harm to self or others. Needs constant supervision (24-hour care) with maximum staffing, in a highly structured setting.**

A. SERVICE NEEDS OF THE CHILD

Children and adolescents at this level of care have acute or chronic emotional or behavior disorders or conditions such that a highly structured program with 24-hour supervision is essential to improved functioning or maintenance. They may present a severe to critical risk of causing harm to themselves or others.

In non-psychiatric facilities, the medically fragile child require a highly specialized residential setting which can safely and effectively care for severe and chronic medical conditions which may be complicated by severe behavioral disorders or emotional disturbance. In cases in which the continuity of life support functions is threatened, a medically oriented facility is required.

Children and adolescents served in non-medical facilities at this level of care require a behavior management program designed to meet their unique needs.

B. MEDICAL CARE

The caregiver provides access to appropriate laboratory and pharmacy services. Individuals administering psychotropic medications must receive training in potential side effects and drug identification.

All non-routine medical care which is unrelated to the emotional or behavioral problems for which the child is placed and all dental care are the financial responsibility of the child placing agency unless prohibited by state or federal law. In some instances the cost of medical and dental care may be the responsibility of the child's managing conservator.

a. In medical facilities, the caregiver provides 24-hour on-duty nursing services, 24-hour on-call medical and psychiatric services, and laboratory and other medical services required to monitor physiological functioning according to the prevailing standards of medical and psychiatric care. Psychotropic and life-support medications are typically adjusted frequently in an effort to reach a stabilized psychiatric or physiological status for mentally ill and mentally retarded children and adolescents.

b. In non-medical facilities, behavior disordered students are insured access to the medical community as necessary with necessary medication administered as prescribed by physician on-contract or on-call.

C. RECREATION ACTIVITIES AND LEISURE TIME

The caregiver provides recreational services through an individualized recreational plan designed by the inter-disciplinary team.

D. EDUCATION

Each child is provided access to a free, appropriate, public education and related services through the local public school district and within guidelines set by state and federal law. To ensure 24-hour programmatic consistency, educational and related services are coordinated with the child's treatment plan.

E. THERAPEUTIC INTERVENTIONS AND CASE MANAGEMENT

The caregiver provides professionally supervised therapeutic interventions within the milieu designed to improve the child's functioning. The caregiver provides formalized behavioral programs implemented by professional staff or paraprofessional staff under the direct supervision of professional staff, and formalized interactions between professional staff and children such as individual group, and family therapy. Formal therapeutic interventions such as individual, group, and family therapy are performed only by appropriately credentialed professional staff.

The treatment plan or individual education plan addresses all waking hours of the child's day. All activities planned and interventions applied are individually designed with the goal of stabilizing the child's severe psychiatric or medical crises or severely dysfunctional level of adaptation. Formalized interventions occur more frequently and more intensively at this level of care in order to bring about stabilization of the child's condition.

Treatment is recommended and approved by a physician at the time of diagnosis and review. In psychiatric facilities, the psychiatrist is responsible for, and thus directs, all aspects of the patient's care. The psychiatrist is responsible for admission, discharge, treatment plan development and reviews, and for ongoing and continuous monitoring and review of medication.

The child placing agency is responsible for the provision of case management services, and a minimum of one monthly contact with the caregiver.

F. STAFF RATIO

Staff-to-child ratio is governed by licensing, certification or monitoring standards. Supervision is required 24-hours a day with capacity available for a higher staff-to-child ratio than is required by licensing, certification or monitoring standards.

G. EXAMPLES OF CURRENT FACILITY OPERATIONS

Children and adolescents served at this level or care typically are served in:

1. an inpatient psychiatric hospital accredited by JCAH and licensed by TDMHMR as an inpatient psychiatric facility.
2. specialized placements in a variety of settings including those regulated by the TDMHMR Community Standards. These provide intensive medical interventions for severely medically fragile, mentally retarded children and adolescents who

require intensive behavioral, educational and programmatic intervention due to their mental disabilities.

3. specialized placements in appropriately licensed facilities for severely impaired children who require a behavioral approach for treatment and education.

Appendix 8.4. Memoranda of Understanding Regarding Services For Children and Youth Mandated by the 70th Texas Legislature

SB 298 **TDH, TDHS, TDMHMR, TRC, TCD, TCB, TEA**

The above agencies will develop procedures and rules to clarify financial and role responsibilities and will devise a way to share data and improve service delivery in serving disabled persons.

SB 298 TDH, TDHS

Develops a strategy to reduce service duplication to coordinate family planning services, to improve maternal health, and to maximize funding to serve priority populations.

SB 298TDH, TDHS, TDMHMR

Hospital and long-term care services.

SB 298TEA, TDHS, TYC, TJPC, TCB, TDH, TRC, TDMHMR

Reduces service duplication to improve the coordination of services to children with multiagency needs. Services must be delivered in the least restrictive environment and are facilitated by developing and implementing a system of community resource coordination groups. "Agencies will share in the cost of providing needed services when the coordination group confirms that the referring agency cannot provide all needed services and when the needed services are within the financial capability and statutory responsibility of other agencies for the designated services." Community Resource Coordination pilot sites are in Tarrant, Travis, Henderson, and Val Verde Counties.

SB 298TYC, TDH, TDHS

Develops guidelines and rules, policies, and procedures for the investigation of child abuse and neglect in child care facilities.

SB 33 **TYC, TDMHMR**

Fosters the sharing of information, services and resources to serve mentally ill and mentally retarded juvenile offenders. Referral, assessment, staffing (treatment plan development), treatment and aftercare planning comprise the model program housed at Austin State Hospital (ASH).

Referrals include youth between the ages of 10 and 17 diagnosed who have an "acute psychiatric disorder (psychosis, affective or organic disorder) and [who], because of this, [are] a danger to self or others. This would include the following DSM III-R diagnoses: Schizophrenia (295), Psychotic Disorder (298 & 297), Bipolar Disorders (296), Major Depression (296), and Acute Organic Disorder." Eligible Youth have not responded to psychiatric treatment or medication, " and hospitalization represents the least restrictive environment."

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Appendix 8.4. (Continued). Memoranda of Understanding Regarding Services For Children and Youth Mandated by the 70th Texas Legislature

SB 33 Continued

Disqualifying Criteria: "A youth who meets one or more of the following should not be referred to ASH.

1. The youth is non-psychotic and unable to form therapeutic relationships, does not learn from experience or shows limited anxiety or guilt regarding behavior.
2. History of runaway and admission to the ASH would place the youth, his family or the community in danger; a maximum security program is needed.
3. History of severe exploitation, victimization or predatory behavior towards peers or younger children.
4. Mental Retardation without a psychiatric disorder.
5. Substance abuse treatment is required.
6. A TYC facility or contract agency is available which would meet the youth's needs for psychiatric treatment."

Services for Youths with Mental Retardation

TDMHMR will assist TYC with mentally retarded youth by listing all residential and day services, and providing a liaison to TYC. The Mental Retardation Authorities (MRA) serving the model program will assist TYC with assessment services. TYC will be responsible financially for youth in their care. Youth who are in parental custody or in community-based care will be eligible for services provided by the MRA.

SCR 58 **TDMHMR, TEA, TRC, TDHS, TDH, TCB**
Fosters coordination among the above agencies for the provision of a necessary continuum of services regarding residential care, treatment, education, training, rehabilitation, and vocational services for handicapped children including those beyond 18 who are in the conservatorship of TDHS.

SCR 135 **TEA, TRC, TDMHMR**
Calls for interagency coordination to better meet the needs of handicapped students transitioning from public education to adult services. SCR 135 extended SCR 129, which expands responsibilities. SCR 129 originally targeted mental retardation services to disabled individuals includes sharing diagnostic information and coordination of educational, vocational and other services for disabled persons to facilitate the transition in order to streamline entry into the various services through shared diagnostic data and comprehensive service coordination. "The Community MHMR centers will be requested to provide transition services as a priority service to eligible persons with mental retardation and mental illness who are in need of these services and

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Appendix 8.4. (Continued). Memoranda of Understanding Regarding Services For Children and Youth Mandated by the 70th Texas Legislature

SCR 135 continued	who are leaving public schools or who have exited public schools and who have been identified as needing these services within budget constraints."
SB 34	**TDMHMR, TDHS** Fosters coordination to provide long-range planning for developmentally-disabled individuals.
SB 65	**TDMHMR, TDHS** A plan to improve evaluation and diagnostic services for emotionally disturbed children referred to TDHS through state facilities is being developed and will be completed by Fall, 1989.
HB 550	**TRC, TCD, and all other agencies serving the deaf** There are approximately ten MOUs being developed to improve coordination of services for the deaf and to reduce duplication.
HB 1010	**Texas Department of Commerce, Texas Department of Corrections, TCADA, TDHS, TEA, TEC, Texas Higher Education Coordinating Board, TJPC, TYC** The Interagency Coordinating Council (ICC) "coordinates policies and services to create a resource network for students who drop out of school or who are at risk of dropping out of school. . . Among ICC provisions are the development of a statewide dropout reduction program, and the implementation of a systematic process for collecting dropout data, and the appointment of an at-risk coordinator in each school district."

Source: Austin and Michie, January 1990, pp. 33-36.

Appendix 8.5. Memoranda of Understanding Regarding Services For Children and Youth Mandated by the 71st Texas Legislature

SB 417TEA & TDMHMR

A continuation of the joint task force on emotional disturbance. Recommendations to the legislature are planned for no later than January 31, 1991.

SB 417TEA, and other state agencies

Directs state agencies to work together to prepare special education students for life after school. The MOU further necessitates adoption and review of individual transition plans for special education students who are at least 16 years old.

SB 417TDHS and other state agencies

Designed to furnish pilot programs in early intervention education and coordinate those services for eligible families.

SB 417TEA, TDHS, TDH, TEC, TDMHMR, THHSCC, Texas Department of Community Affairs, and a representative from the Child Support Enforcement Division of the Attorney General's Office

Establishes the School Age Pregnancy Interagency Coordinating Council and directs the Council to report to each legislative session on recommendations concerning teenage pregnancy issues.

SB 1019 **TEA, TDMHMR**

Appropriates $2 million to TEA for provision of non-educational community-based support services. When these services affect children with MR, autism, or SED, application for these funds is made jointly by the local school district and the local mental health or mental retardation authority. This should affect 100 to 130 children statewide.

SB 1175 **TEA, TDHS, TJPC**

Targets school-based counseling for abused children by designating the State Board of Education/TEA to contract for school-based counseling programs in one or more schools in at least 16 rural and urban districts. Funding of these programs will come from the imposition of fees in conviction of certain offenses. The commissioner of education will appoint an evaluation team to participate in the design and evaluation of the program.

SB 1668 **TEA, TCADA**

Targets students at risk of dropping out of school and addresses parental duty to require school attendance. "Requires juvenile courts to give priority to complaints regarding extended student absences; requires cooperation among school district liaison officers for court-related children, at-risk coordinators, and local juvenile and law enforcement personnel; requires TEA to contract for counseling services for abused children in a selection of at least 16 schools. Provides drug abuse prevention and

(Continued Next Page)

Appendix 8.5. (Continued). Memoranda of Understanding Regarding Services For Children and Youth Mandated by the 71st Texas Legislature

SB 1668 continued

intervention programs and technical assistance; provides funding weight for non-handicapped students residing in care and treatment facilities in districts in which their parents or guardians do not reside."

Sec. 71.011 **TDHS, TYC, TJPC**
Develops or expands nonresidential community contracts to help families with multiple needs in each agency's client population. "The Texas Department of Human Services shall act as the lead agency in coordinating the development and implementation of the memorandum. The memorandum for service contracts should include parenting skills training, coping skills training for youth, including communication, problem solving, decision making, and conflict management skills, support groups for children of substance-abusing and dysfunctional families, including support groups for the parents of children and individual counseling for a limited number of crisis referrals from the support groups. The agencies jointly determine the pilot counties in which the joint contract proposals are to be developed. Each agency will be responsible for determining the portion of agency funding designated for each type of contract to serve people and joint requests for proposals to be issued for services."

Sec. 71.013 **TDHS, TDMHMR, TYC, TJPC, TEA**
Develops interagency training for agency staff involved in assessment, case planning, case management, and in-home or direct delivery of services to children, youth, and their families. The lead agency will be TDMHMR. The MOU must outline each agency's responsibility in coordinating and developing a plan for interagency training on individualized assessment and effective intervention and treatment services for children and dysfunctional families.

Sec. 71.014 **TDHS, TJPC**
Develops and coordinates service delivery for runaways.

Sec. 71.015 **TDOC, TDHS, TDMHMR, TJPC, TEA, TYC**
Targets dropouts and youth at risk of becoming dropouts by accessing JTPA funds. The lead agency will be the Texas Department of Commerce (TDOC) and will establish guidelines for youth to access Texas Job Training Partnership Act Funds.

Source: Austin and Michie, January 1990, pp. 34-40.

References

Alaska Department of Health and Human Services. 1989. Status Report: The Alaska Youth Initiative. By Child and Adolescent Services, Alaska.

Austin, David, and Ida Michie. 1989. Community Resource Intervention Notebook. (Draft, September 5) Community Interventions Task Force of the Commission on the Mental Health of Adolescents and Young Adults. The Hogg Foundation for Mental Health. Austin, Texas.

Austin, David, and Ida Michie. January 1990. Community Resource Intervention Notebook.(Final Draft) Community Interventions Task Force of the Commission on the Mental Health of Adolescents and Young Adults. The Hogg Foundation for Mental Health. Austin, Texas.

Celeste, Richard F. 1989. Governor, State of Ohio. Memorandum to Local Cluster Chairperson,the State Interdepartmental Clusters of Ohio, September 1.

Frank, Mary Jane. September 1989. "Clustering in Ohio." (Draft.)

May, Janice C., Stuart A. MacCorkle, and Dick Smith. 1979. Texas Government. New York: McGraw-Hill.

McClesky, Clifton, et al. 1978. The Government and Politics of Texas. Boston: Little, Brown and Company.

Ohio H.B. 304. 1987. Reg. Sess.

Olsen, Tom. 1989. Project Coordinator, Children, Youth and Families, Texas Health and Human Services Coordinating Council, Austin, Texas. Interviewed by Sandra Clark, November 9, 1989.

Olsen, Tom. 1989. Project Coordinator, Children, Youth and Families, Texas Health and Human Services Coordinating Council, Austin, Texas. Presentation to LBJ School of Public Affairs Class. October 31, 1989.

Texas Senate, Special Committee on Delivery of Human Services in Texas. November 1980. The Potential in the Patchwork: A Future Pattern for Human Services in Texas. Austin, Texas.

Texas Health and Human Services Coordinating Council (THHSCC). February 1989. Children and Youth in Texas: A Proposal for Coordinated Services. Austin, Texas.

____________. December 1988a. Biennial Report 1987-1988. Austin, Texas.

____________. December 1988b. Strategic Partnerships: Health and Human Services for the Future. Austin, Texas.

____________. March 1985. A Spectrum of Services for Texas Children in Residential Care. Austin, Texas.

VanDerBerg, John, 1989. "Alaska's Services for Youth with Emotional Problems: A Bright New Hope." Coping, October 5.

Chapter 9. Private Providers of Services for Severely Emotionally Disturbed Children and Adolescents in Texas

Private organizations function as alternatives to the state in the provision of services for severely emotionally disturbed children and adolescents through state contracts and private funding. Inadequate services for children are a result of the state's lack of funding and interagency coordination, while inappropriate services may be a result of funding that encourages hospitalization over community and outpatient programs. This chapter discusses the providers in the private sector, primary services offered, problem issues expressed by some of the providers, and recommendations for change.

TYPES OF PRIVATELY PROVIDED SERVICES

Residential treatment refers to any program that requires the child be moved from the home whereas nonresidential services are those that can be provided while the child remains with the family of origin. The most commonly used residential services are inpatient hospitalization, residential treatment centers, and foster care. These resources are used when nonresidential interventions have failed (Turner, 1988, p. 12).

Residential Services

Discussion of residential providers will begin with inpatient hospitalization and progress through residential treatment centers and then foster care. Less frequently used residential services will then be discussed.

Inpatient Hospitalization. This type of treatment is defined as a licensed psychiatric hospital or inpatient hospital with a psychiatric unit which follows the medical model as the basis for treatment planning. The medical model's basic tenets are that mental illness has biological causes and treatments and can be treated with medication. The psychiatrist is in charge of the treatment team. Milieu therapy (modeling a normal, healthy environment for the child) and psychotherapy (group, individual, and family counseling) are enhanced by the pharmacotherapy (which is provided to increase effectiveness of the other therapies) (Lyman, Prentice-Dunn, and Gabal, 1989, p. 163).

Psychiatric hospitals are often "locked units," meaning that the child or adolescent cannot leave the facility. This makes them the only appropriate setting other than criminal detention centers for assaultive or self-destructive patients. Inpatient hospitalization units are also taking over treatment areas for eating disorders and chemical dependency because private insurance offers reimbursement for such services.

The population of children served by inpatient hospital units can be categorized according to symptoms the children exhibit or funding source for the child's treatment program. The Texas Network for Children, Youth, and Families surveyed Texas providers of services to children and youth in 1988 with 302 programs and residential facilities responding. Of those providers who responded, 79 were licensed as psychiatric facilities. The most commonly cited symptoms listed by these participating inpatient units included diagnoses of emotional or behavioral disorders characterized most frequently by neglect at home, emotional abuse, physical abuse, or sexual abuse by the parent toward the child, self-abuse, suicide attempt, aggression, substance abuse, hostility or resistance to treatment, or inability to function in the schools.

Payment sources most frequently listed by those inpatient hospitals responding in the Texas Network for Children survey included parents or family, private insurance, Champus, and Champva. Less frequently listed funding sources included the Texas

Department of Mental Health and Retardation, juvenile probation, and local school districts.

Fees reported in the survey range from $150 a day to $700 a day. Most frequently reported average length of stay was one month (listed by 12 out of a total of 79 facilities), followed by 45 days (reported by 9 facilities), and two months (reported by 7 facilities). There are 6 facilities that treat children and adolescents for an average stay of nine months; these hospitals take patients who are more difficult to treat. This compares to national data showing average length of hospital stay in a private psychiatric facility for this age group to be 36 days (U.S. Congress, OTA, December 1986, p. 26). As of December 1988, there were 6,925 private psychiatric beds operated in Texas, of which 44 percent (or 3,047) were designated for children and adolescents ("Mental Health Business Scrutinized for Ad Blitz," 1989, p. 1). Rapid growth in private inpatient psychiatric facilities is illustrated by the fact that 38 of the 81 licensed private psychiatric hospitals in Texas have opened since January 1986. Moreover, acute care general hospitals have also increased the numbers of beds available for adolescents and children with mental illness in recent years. Statistics from the National Association of Private Psychiatric Hospitals showed that in 1988 only 22 percent of its members' discharges were children and adolescents ("Mental Health Business Scrutinized for Ad Blitz," 1989, p. 1). Unproportional to that statistic is the 44 percent of Texas' total psychiatric beds that are dedicated to children and adolescent treatment. This overabundance of beds proportional to the demonstrated need causes some individuals to fear an abuse of insurance benefits for mental health hospitalization. Others argue that the low statistics demonstrate inadequate treatment for this group, that hospitalization for mental health is just beginning to address an unmet need, and that admission rates will continue to grow as hospitalization becomes more available and less stigmatized.

To maintain occupancy rates of the increased number of psychiatric beds, private hospitals market to insurance-covered clients. For instance, in its annual report, a private psychiatric hospital corporation explained leased office space for 100 free-standing counseling centers as a marketing strategy. The report stated that the mental health professionals who lease space perform assessments and treatments and refer (when appropriate) to psychiatrists on staff at the local corporate hospital, thus expanding the hospital's market (Charter Medical Corporation, 1987, p. I-4). Most therapists in private practice see funded patients, not those who lack insurance or family payment. Another corporation states that its outreach program to clergy, school counselors, teachers, judicial, and law enforcement systems has increased community sources for referrals to their facilities, making them less dependent on initial involvement of psychiatrists for admissions (CPC, 1988, p. 3). Most probably, the initial assessment includes a question about insurance coverage of mental health services. Some hospitals in the Dallas-Ft. Worth area provide counselors to the public schools free of charge; it is beneficial to both parties because the schools get help they wouldn't normally have and the hospital can screen for potential admissions ("Mental Health Business Scrutinized for Ad Blitz," 1989, p. 1). Through marketing, private hospitals increase the odds that a child with insurance will be hospitalized.

Medicaid coverage is another example of insurance-induced hospitalization rather than community services utilization. Children on AFDC have limited Medicaid reimbursement for psychiatric services; in Texas to be covered, treatment must be provided in an acute care general hospital with a psychiatric unit, of which there are 45 in the state. (TDH, 1988). Texas does not pay for care for persons under 21 in free-standing mental hospitals even though that is an optional program under the federal Medicaid program. Nationally, the length of stay for psychiatric hospitalization for children and adolescents in 1980 in an acute care hospital similar to that which is reimbursed by Medicaid in Texas was two weeks (U.S. Congress, OTA, December 1986, p. 26).

Another trend that has led to increased adolescent psychiatric hospitalization in the last decade was galvanized by the 1974 Juvenile Justice and Delinquency Prevention Act which encouraged placement of troublesome youth in facilities other than adult jails or juvenile-detention centers. National trends show an increase in private free-standing psychiatric hospitals from 184 in 1980 to 450 in 1988 ("Committed Youth," 1989, p. 66). Examples of for-profit providers which have increased beds in Texas since 1974 include the Hospital Corporation of America (HCA) hospitals across the state, with 14 facilities providing 572 psychiatric beds for children and adolescents; the CPC system, with 5 hospitals across the state providing 208 psychiatric beds for children and adolescents; and the Charter system of 10 hospitals, providing 332 psychiatric beds across the state for children and adolescents. In addition to those chains there are many more Texas inpatient private psychiatric hospitals serving this population (Appendix 9.1).

In contrast, admission rates for children at state and county mental hospitals declined by 30 percent while admissions to private psychiatric facilities increased by almost 200 percent during the 1970s (U.S. Congress, OTA, December 1986, p. 25). Between 1975 and 1984, 85 public psychiatric hospitals closed (Schlesinger and Dorwart, 1984, p. 964). In Texas, 548 beds are provided for children and adolescents by the public sector, compared with the 3,047 beds in the private sector (Sutton, 1989). Private-sector contracts for mental health are replacing direct public provision of services in an attempt at reducing costs. Results of the Texas Network for Children survey seem to indicate that Texas Department of Mental Health and Mental Retardation is not a large contractor of private psychiatric inpatient services. These children either go without treatment or go to residential treatment centers.

A recent study on inpatient care for schizophrenia in California found that reimbursement source and facility utilization varied significantly by age. This study examined all mental health discharges from hospitals in California in 1984 for which schizophrenia was given as a first diagnosis or a secondary diagnosis when a mental health diagnosis was given as the first diagnosis. Private for-profit hospitals in California were found to specialize in younger persons with a diagnosis of schizophrenia. It was found that these for-profit psychiatirc hospitals capture a larger share of the 0 to 19-year-old cohort of schizophrenia discharges (20 percent) and days (24 percent) than they do of all age cohorts (9.1 percent) and days (5.4 percent). Similarly, state mental institutions' share of the discharges fo the 0-19 population (5 percent) and their share of the days (31.9 percent), were significantly lower than their chare of total schizophrenia discharges (10.3 percent) and days (42.3 percent) overall. For this age group, it may be that the existence of third party coverage leads to hospitalization outside of state mental institutions (Crumpton et al, 1989, pp. 7-8).

When the study examined the sources of payment for schizophrenia discharges, it was found that those in the 0 to 19 age bracket have better private insurance coverage. Of all discharges in this age bracket, 39.6 percent were covered by private insurance compared to 14 percent of all discharges. When people aged 20 and 21 are included, the total number of discharges who are privately insured amounted to 32 percent. In other words, dependent coverage had apparently already dimished substantially between those 19 and under to those 20 and 21 years of age (Crumpton et al, 1989, pp. 12-13).

One cost difference between the public and private sector involves the population each serves; government institutions have an obligation to provide services to all citizens regardless of ability to pay, whereas proprietary and not-for-profit private institutions generally have no such obligation. Data from 1975 hospital studies indicate that between 3 and 4 percent of admissions at private institutions had no funding or inadequate funding as opposed to 33 percent at public institutions (Dorwart and Schlesinger, 1988, p. 549). In Texas, there are estimates of 100,000 children and adolescents with severe problems requiring professional treatment who do not have insurance coverage or private resources to cover the costs (Texas Health and Human Services Coordinating Council, February 1989, Appendix B, p. 3). Some private facilities do offer care at a reduced price to uninsured clients or write off the uncollected funds as bad debt, so in some cases these costs would not be reflected in the data on uncompensated care reported above. Screening out high-cost clients or those who might be difficult to treat is also a problem in the present system of privatization. Data investigating such allegations are not available, and future research into this area would be beneficial.

Besides denial of difficult or unfunded admissions, the issue of access to care may also involve long distances between the child's home and hospital. Most of these private psychiatric hospital beds are clustered around the larger cities, such as Dallas-Ft. Worth, Houston, Austin, San Antonio, and Corpus Christi. For example, out of the 45 acute care hospitals in the state, 25 are located in the above cities or surrounding metropolitan areas. This may causes access problems for those children living in rural areas of Texas. Follow-up care is also hindered if the child lives a great distance from the hospital.

In summary, a service is being provided by the private sector while the profit motive is being served. Public relations and marketing are facts of life in hospitals according to Dr. Paul Fink, past president of the American Psychiatric Association ("Mental Health Business Scrutinized for Ad Blitz," 1989, p. 1). Dr. Arnold S. Relman refers to the trend of private business corporations taking over a service traditionally provided by not-for-profits or public institutions as the "new medical-industrial complex." He argues that efficiency may be increased through privatization, but overuse of facilities, fragmentation of services, the choice of less ill patients with insurance coverage over those more in need, and increased power in national health policy by the private corporations are accompanying drawbacks. He concludes that increased privatization will require increased government regulation of the services provided (Relman, 1980, p. 963).

Residential Treatment Centers. Residential treatment centers are similar to inpatient hospitalization units but differ in that they depend less on psychiatric leadership and the medical model (National Institute for Mental Health, August. 1985, p. 1). The National Institute for Mental Health defines a residential treatment center as one meeting the following four criteria: an organization, not licensed as a psychiatric hospital, whose primary purpose is the provision of individually planned programs of mental health treatment services in conjunction with residential care; it has a clinical program within the facility directed by a psychiatrist, psychologist, social worker, or psychiatric nurse at or above the master's level; it serves children primarily under age 18; and 50 percent or more of the children admitted primarily for emotional disturbances or mental illness can be classified by DSM III-R codes other than those codes for mental retardation, substance-related disorders, and alcoholism (National Institute for Mental Health Statistical Note, 1989, p. 5).

Approaches to treatment run the gamut but most frequently are based in the social model or the medical model (Turner, 1988, p. 14). Residential treatment centers using the medical model are usually associated with a hospital, led by a psychiatrist, and depend on pharmacotherapy and psychotherapy; they lack a hospital license. Residential treatment centers using the social model depend on a treatment environment that is "protective and nurturing" (Turner, 1988, p. 14). These centers are not usually locked facilities, meaning the children have no physical restrictions to protect against their leaving the premises. Services provided in residential treatment centers besides 24-hour supervision include psychotherapy, recreational therapy, and occupational therapy or vocational training.

A discussion of the population of children served in residential treatment centers can be approached from a description of symptoms exhibited by the children or from the aspect of funding for services. Residents are usually diagnosed with conduct disorders or behavior disorders with the following characteristics most frequently listed by the respondents to the Texas Network for Children survey who serve at least Level IV children: neglect at home, emotional abuse, physical abuse, or sexual abuse by the parent toward the child were listed by at least half the respondents (total residential treatment center respondents numbered 51). Characteristics listed by one quarter of the respondents included aggression characterized by fighting, intimidation, or threatening behaviors; stealing; running away from home; substance abuse; learning disability; truancy; and inability to function in public schools. Half of the IQ scores ranged from 70 to 84 and half were 85 or above. Comparing these data to those for the inpatient psychiatric hospital population shows differences in aggression--hospitals listed self-abusive behaviors and suicide as common characteristics whereas residential treatment centers listed aggression toward others as more common behaviors.

Payment sources listed in the Texas Network for Children survey of providers include (in order of frequency reported) Texas Department of Human Services, juvenile probation departments, parents and family, Texas Education Agency and local school districts, donations, gifts and grants, Texas Youth Commission, Texas Department of Mental Health and Mental Retardation, United Way, private insurance, Champus, Champva, and fund-raising by the residential treatment centers for those children who lack adequate funding from the other listed sources. Comparing this to the inpatient hospital funding sources, it is obvious that residential treatment centers are the preferred contractors for state-agency-sponsored children. The following discussion of fees may indicate why this is true.

Fees listed in the survey range from $39 per day on a sliding scale to $350 per day, with $65 the most commonly listed charge (by 14 respondents out of 30 who chose to answer regarding rates). The more expensive residential treatment centers were licensed as such but listed programs based in the medical model (locked units, treatment team headed by psychiatrists and composed of nurses) with private insurance or Champus as their source of payment. The average length of stay most frequently listed was 15 to 18 months, with the more expensive units listing periods of three weeks to 3 months.

As of November 1989, the Texas Department of Human Services had 62 providers licensed with 3,066 beds, most of which were located in larger cities in Texas or in rural settings. Either option is frequently a distance away from the child's family, which inhibits family therapy (Texas Health and Human Services Coordinating Council, February 1989, Appendix B, p. 4; Stroul and Friedman, 1986, p. 56). Residential treatment centers are used frequently because of the dearth of alternative community services available to this population (Texas Health and Human Services Coordinating Council, February 1989, Appendix B, p. 4; Melton, 1984, p. 25). A summary comparison of residential treatment center characteristics with inpatient hospitalization is shown in Table 9.1.

Many of the children in residential treatment are placed by court order and do not have the option of going home. A judge has ruled that the parents were either abusing or neglecting the child to the point of losing their rights to raise that child. In these cases a continuum of care providing foster care is mandatory, and preferably therapeutic foster care.

Foster Care. Foster care started in the mid-19th century as an alternative placement for children of poor families. The Children's Bureau became responsible on the federal level for foster homes. More recently, federal dollars have been allocated for foster care, from which has developed a concept "intended to make placement possible for poor children when states claimed that their homes were unsuitable for an AFDC grant (and when a court determined that placement was necessary)" (Kamerman and Kahn, 1989, p. 45). Whereas poverty was once the underlying factor for placing a child in foster care, presently physical, sexual, or emotional abuse are the contributing causes (Kamerman and Kahn, 1989, p. 182). With this situation comes the associated emotional scars requiring therapeutic healthy environments to reinforce normalcy and deal with the effects of the past on the child as well as a need for permanent placement of the child outside the home for the safety of the child.

Therapeutic foster care involves placement in an alternative home with foster parents to provide a healthy, intimate setting. It includes thorough training, supervision, and support for the foster parents and psychiatric, psychological, and educational community support services for the child. Thus it differs from the more traditional type of foster care which does not offer the extra training and support.

Table 9.1 Comparison of Residential Treatment Centers with Inpatient Hospitalization

Type of Facility	Fee Range	Payment Source	Number of Facilities	Characteristics of Client Population	Average LOS
Private hospitals -national	$325-$375**		381***	Aggressive Suicidal Overtly Psychotic**	36 days**
Private hospitals -state	$150-$700*	Parents/ Family Private Insurance Champus/Champva Public Agencies* Public Agencies*	81***	Emotional or Behavioral disorders with suicide attempt, self-abuse, aggression, Substance Abuse, hostility to treatment, inability to function in schools*	1 month
Residential Treatment Centers-national				Non-psychotic with conduct or personality disorder**	2 months to 2 years
Residential Treatment Centers-state	$39-$350*	TDHS, Juvenile Probation, Parents/ Family, TEA, local school, districts, donations, gifts and grants, TYC, TDMHMR, United Way, CHAMPUS/ Champva *	62****	Conduct or behavior disoders with aggression stealing, running away, substance abuse, learning disability, truancy, inability to function in public schools	15 to 18 months

Sources:
- * TNC, 1989.
- ** US Congress (OTA), 1986, pp. 79-86.
- *** "Mental Health Business Scrutinized for Ad Blitz," 1989.
- **** TDHS, 1987.

Group foster homes are another residential service option considered as foster care. In this residential setting, a small number of children live in a neighborhood environment with trained mental health workers serving as advocates and counselors. In Texas, licensing requirements limit care to 6 to 12 children per facility. Many of these facilities refuse children who fit into the severely emotionally disturbed category.

Most SED children are immediately institutionalized (Stroul and Friedman, 1986, pp. iii, v) because they are too difficult for foster parents to handle and therefore difficult to place in foster homes (Weithorn, 1988, p. 795). When behavior indicates readiness, the child progresses into a less restrictive environment, such as foster care. Foster care, besides being provided by families recruited and paid through public agencies, can also be provided by individual families who are recruited and trained by private organizations. For example, the Lena Pope Home in Ft. Worth offers foster care across the state for children who have been discharged from the Lena Pope Home. The Casey Family is a not-for-profit agency started by James Casey of the United Parcel Service. The caseworker takes the role of conservator, replacing the Texas Department of Human Services caseworker, and arranges foster care families for children who have been abused or neglected. A stipend rate set by the private agency is paid to the foster parents in return for parenting the child. Rates set by the private sector are usually higher than those stipend rates set by the public sector. The private organizations can also pick and choose their children to place; therefore, SED children are often bypassed in the private sector for less difficult cases (Weizanbaum, Interview, December 4, 1989).

According to K. Carpenter, statistician at the Texas Department of Human Services, in FY 1989, Texas had 2,421 individual and group foster homes, of which 70 were therapeutic foster homes. Out of the 6,024 children being provided foster care, 1,120 were diagnosed as having an emotional disability. Though this number of therapeutic foster homes seems small, it represents a great increase from 1984, when there was one home licensed by TDHS to provide therapeutic foster care (Table 9.2).

The Texas Department of Human Services has no recorded data on privately trained and operated therapeutic foster homes. Data from records on Texas foster care indicate that typically a child will stay in care for 30 months, with an average of 2.5 moves during the time in protective custody (Texas Health and Human Services Coordinating Council, February 1989, Appendix B, p. 5).

Table 9.2 Growth in Therapeutic Foster Homes Licensed by the Texas Department of Human Services, 1984-1989

Number of Therapeutic Homes Licensed	Year
1	1984
3	1985
28	1986
64	1987
70	1988

Source: K. Carpenter, Texas Department of Human Services

Therapeutic Camps. Therapeutic camps are another residential environment available in Texas to severely emotionally disturbed children. They focus on meeting the basic needs of life: food, clothing, and shelter. Group interaction and group problem-solving with attention to development of delayed gratification and controlled behavior are methods and goals of treatment (McElrath, 1984, p. 8). Camps are located in the rural areas of Texas, making it difficult for children to run away, so they are forced to stay and work on their behavior and emotional problems. This type of setting is generally not appropriate for psychotic and mentally retarded children because of the physical skills needed to survive. There are seven camps licensed by the Texas Department of Human Services, with 268 children potentially served.

Crisis Residential Centers. Also called emergency centers, these crisis centers can provide basic care for up to 30 days for children. A crisis can be short-term, as in the case of a child who needs a place to stay until the parents are released from jail. More serious and long-term arrangements must be made in other situations. Common recipients of emergency or crisis services are runaway children. In Texas, most crisis centers will not accept children who are not in the care of a state agency (Texas Health and Human Services Coordinating Council, 1989, Appendix B, p. 4). This creates a large service gap for children--like runaways--who need crisis help but are in the 58 percent of reported abuse cases not investigated by Child Protective Services (Texas Department of Human Services, June 1988, p. 13). Another gap in crisis residential care is psychiatric support services for those children and adolescents at the shelter (Texas Department of Human Services, June 1988, p. 3). There are 50 shelters licensed in Texas with 997 beds. This does not meet the demand.

Nonresidential Services

Less disruptive to family life for the child, nonresidential services attempt to solve family crises and to teach families how to change along with the child. By not pulling the child from the home, they avoid the issue of reintegrating the child into the family (Weithorn, 1988, p. 794). Moreover, no matter how bad a situation appears to an outsider, most children still want to maintain family bonds (Stroul, 1988, p. 2). And children report family and foster care intervention as more supportive than residential treatment centers (Melton, 1984, p. 17). Not only do these services offer the child an opportunity to stay at home, they are also less expensive to provide.

Outpatient Therapy. The least restrictive and most popular treatment alternative in the present system, outpatient therapy consists of sessions with the child and/or family and a trained counselor in the counselor's office or clinic. Effective delivery of services includes three concepts: timeliness of the treatment (i.e., how quickly treatment is begun once a recommendation has been made), intensity of treatment (number of hours per week), accessibility of treatment to client (i.e., whether transportation is easily available), and flexibility of the counselor's hours in fitting into the child's and family's schedule (Stroul and Friedman, 1986, p. 39). It is least likely to have positive results for children with generalized conduct disorders (Melton, 1984, p. 12).

Outpatient therapy can be provided by social workers with a master's degree, psychiatric nurse practitioners, psychologists, psychiatrists, and less traditionally trained persons like psychics and iridologists. According to the Texas Psychiatrist Survey conducted in 1988, private-practice psychiatrists are seeing patients with eating disorders, developmental disorders, and conduct disorders in greater numbers than the publicly employed psychiatrists. Children and adolescents are much more likely to be served by a psychiatrist in private practice than one in a public agency. The survey also revealed a shortage of child psychiatrists in the state; of the 789 respondents to the 1988 survey, 29 percent see child clients but only 2.5 percent (20 psychiatrists) spend at least half their practice time dealing with children and child psychiatry; the rest of their practice is dedicated to adults. Adolescent psychiatry attracts 4.8 percent of the psychiatrists in the state as compared with 57 percent who practice adult psychiatry (TDMHMR, November 1988).

Social workers with a master's degree provide services as administrators of residential homes, program directors, case-workers at both public and private agencies, and therapists. They work in chemical dependency treatment centers, correctional facilities, mental health facilities, and hospitals. Psychologists perform primarily in roles of evaluation and testing or therapy. They practice in hospitals, and schools and privately. Generally speaking, social workers are trained to assist individuals with their external environment (public assistance, family intervention, etc.) whereas psychologists are trained to work with an individual's inner environment (internal conflict, self-control, reactions to family interactions, testing the child's functional ability to interact with the environment, etc.).

Prevention and Early Intervention. The primary goal of early nonresidential service is prevention. Interventions of this type are for individuals and families of individuals who have not yet been identified as emotionally disturbed. For example, children at high risk of becoming severely emotionally disturbed are appropriate for protective day care and programs for developmental delay.

Prevention can be subdivided into services that enhance positive mental health and promote competence (such as the Pebble Project in Austin and Boys Club of America) and self-help groups with support systems for education, information, and encouragement (such as CEDEN in Austin).

Closely related to prevention is screening and early intervention. Once a problem has been identified, providers educate about mental health and offer consultation. Examples of this kind of provider include Child and Family Services and the Child Guidance Centers around the state.

Day Treatment. Another nonresidential service is day treatment, also called partial hospitalization. The emphasis is on creating a therapeutic-educational environment with family counseling, vocational skills, and mastery of emotions taught along with school classes (Melton, 1984, p. 28). Data suggest that it is an effective treatment setting with high reintegration of clients into their communities upon discharge (Melton, 1984, p. 29). Day treatment centers are low in cost yet not covered by insurance carriers as readily as hospitalization. Therefore, this option has few insurance dollars to "drive" the market. According to the 1988 Texas Department of Health/American Hospital Association/Texas Hospital Association survey, 35 of the 182 hospitals responding offer a partial hospitalization program at their facility. Once again, if these services are available, then they are located in large cities with teaching hospitals, and the rural areas are at a loss.

Home-based Services. Home-based services are not available except through several state-initiated pilot programs (Texas Health and Human Services Coordinating Council, February 1989, p. 13). They are the most intensive approach to treating a child and family in the home (Stroul and Friedman, 1986, p. 43). Services are short-term and crisis-oriented, with an emphasis on social service and mental health support for the family unit rather than just the child (Melton, 1984, p. 29). Studies, though few in number because of the newness of the idea, indicate a reduction in family crises and reduced utilization of residential treatment centers (Melton, 1984, p. 30). Problems with home-based interventions occur when members of the family fail to cooperate in providing a healthy home environment for a growing child (Weithorn, 1988, p. 815). For example, a majority of the children in residential treatment centers are placed there because the parent at home is neglecting or abusing the child and returning home is not possible (Stroul and Friedman, 1986, p. 57). If parents are unwilling or unable to change their behavior in raising the child, the child's home situation will not improve.

Vocational Services. Providing work experience and job training are the goals of vocational support services. After training has been provided and the adolescent is working, severely emotionally disturbed youths need an intensive follow-up program to maintain them in their jobs. This is a very effective form of treatment with conduct-disorder adolescents (Melton, 1984, p. 13). Gulf Coast Trade Center in New Waverley provides job training and career placement for those adolescents who have been involved with the Texas Juvenile Probation Commission and Texas Youth Commission.

Organizations providing this service for this population are in great demand and are also scarce.

Recreational Services. Organizations that provide relationships for SED children with significant others outside of the family (Stroul and Friedman, 1986, p. 67) include Court Appointed Special Advocates (CASA). This type of organization provides opportunities for positive role models. CASA also provides voluntary case management for TDHS children.

Case Management. A popular idea in medical management presently, case management appears to be the buzzword of the next decade for efficient, cost-effective, holistic management of severely emotionally disturbed children and adolescents. Aftercare is the term preferred by Texas providers. It is rarely found in the private sector. Case management revolves around coordination and financing of a holistic system of care for the child. Issues presently being discussed include who provides the case management, who pays, and who gets included under the coordinated services to be managed.

Advocacy. Severely emotionally disturbed children and their families need avenues to communicate their needs to policymakers. Advocacy groups include local Mental Health Associations (MHAs) in Texas; Advocacy, Inc; Houston Advocates for Mentally Ill Children (AMIC); and the Texas Network for Children (TNC), which attempt to educate lawmakers and voters on the needs of this population. Membership is made up of parents, mental health professionals, and interested others. Dr. Irving Phillips, of the Department of Psychiatry at the University of California, San Francisco, urges a greater participation of professionals as advocates because of their knowledge, communication skills, and visions to "develop a system that assures better access to adequate services for families who need them" (Phillips, 1990).

Other Social Services. Respite care is a social service along with protective services, financial services, home aid services, shelter services, and adoption (Stroul and Friedman, 1986, p. 62). Respite care is not currently available to this population through the private sector. Adoption is another service provided by the private sector; these agencies are licensed by the Texas Department of Human Services. Health services, another aspect of social services, are provided by private physicians. Doctor offices could be one location that provided screening, prevention, and early intervention or referral for counseling since physicians have more contact with preschool children than other community resources.

RELATIONSHIP OF PRIVATE PROVIDERS TO THE STATE

Private providers are licensed by the state. They also receive some clients from state agency conservatorship and thus collect state payment for services provided. This section of the chapter will discuss the regulation and contracting between the state and private providers.

In 1921, Texas instituted the first law for licensing child care facilities through the state health department. In 1939 the responsibility was delegated to the Department of Human Services, then called the Department of Public Welfare.

In 1975, the Child Care Licensing Act increased the agency's responsibilities to include regulation of child care facilities and child-placing agencies. Minimum standards were developed and enforced through licensing, certification, and registration to provide the needed protection. The purpose of the licensing division of the Texas Department of Human Services is "to protect the health, safety, and well-being of children in child care facilities, while also protecting the rights of child care providers" (Texas Department of Human Services, January 1989, p. 49). The law covers any out-of-home placement where a child lives 24 hours a day or is cared for during the day, the exceptions being a home with less than three children or a home where a relative is caring for the child. The Texas Department of Human Services presently has the responsibility for regulating child care facilities and child-placing agencies through licensing mandated by the State Human Resource Code Annal, Chapter 42.

Licensing by the Texas Department of Human Services sets minimum standards for child care facilities. These standards address administrative record keeping, staff training, child-staff ratios, admission policies, plans of service, use of restraints, and basic child care guidelines. For residential treatment centers, requirements for program director and professional staff are clearly stated. Nonprofessional staff are required to have "at least 40 hours of supervised child care experience in the facility before they are assigned as the only staff responsible for a group of children" (Texas Department of Human Services, 1987, p. 33). Minimum standards for staff-child ratios for residential treatment centers require "at least one child care worker for every four children under age 5 and one child care worker for every eight children 5 years old and older" (Texas Department of Human Services, 1987, p. 32).

Besides defining staff-child ratios and staff training requirements, TDHS's Consolidated Standards for 24-Hour Child Care Facilities sets standards specific to residential treatment centers, therapeutic camps, and halfway houses. These minimum standards cover admission policies and procedures, treatment plans, use of restraints and seclusion as treatment protocols, and health, safety, and environmental requirements for facilities.

Another publication outlines minimum standards for foster group homes, child-placing agencies, emergency shelters, and foster family homes. Minimum standards for therapeutic foster care (as opposed to "regular" foster care) require that the child-placing agency or independent home must have a professional treatment team consulting on the treatment plan for SED children in residence. The professional consultants must include a licensed physician who specializes in children with psychiatric disorders, a psychologist, and a social worker. The standards also require that the foster parents must have "at least 50 hours of documented inservice training annually," which includes instruction on "understanding the needs of residents, residents' families, and State licensing standards" (Texas Department of Human Services, February 1980, p. 45).

The Texas Commission on Alcohol and Drug Abuse licenses chemical dependency units according to state legislation enacted in 1985. The Texas Department of Mental Health and Mental Retardation licenses private inpatient hospital programs. This agency's mission is "to encourage local agencies and private organizations to assume responsibility for the effective administration of mental health and mental retardation services, with the assistance, cooperation, and support of the Texas Department of Mental Health and Mental Retardation" (Texas Mental Health and Mental Retardation Act, June, 1980). The Texas Youth Commission, Texas Juvenile Probation Commission, and Texas Department of Health also license facilities. One recommendation from the Texas Health and Human Services Coordinating Council is to consolidate licensing to one central body (Texas Health and Human Services Coordinating Council, February 1989, p. 31).

Each nonresidential service provider must meet requirements for licensing particular to that discipline. For example, psychologists must pass their licensing and certification exam and maintain the standards required for continuing education or peer review according to the State Board of Psychologists. Likewise, most day treatment programs are associated with a hospital which must meet licensing standards set by the Texas Department of Health or the Texas Department of Mental Health and Retardation. At this time, nonresidential services have less regulation than the residential service providers.

RECOMMENDATIONS

The number of private organizations that provide advocacy for children (such as CASA in Austin) needs to be increased. When providing services for state-agency-sponsored children, there is a need to provide continuity for the child. According to the staffs at the Odyssey Harbor, New Horizons Ranch, and Lena Pope Home residential treatment centers, children are being pulled from the treatment center prior to completion of the treatment plan because of the funding needs of the public agency responsible for that child. Besides providing inadequate treatment for that individual child, it has an effect on morale and cooperation of the other children in the center. The other residents feel that it does not matter whether they cooperate with staff and housemates to complete their treatment plan because they have no control over the end result. The state agencies watch their budgets, and the child's needs take a second seat to cost; therefore, an objective third party concerned with the best interests of the child can provide continuity of care that is otherwise lacking. Along with increased child advocacy, the mental health system needs to be client-centered rather than funding-centered. Insurance must not be the deciding factor as to the type of service the child receives or the length of treatment. Not only do case managers need to advocate for the child on an individual case level, but advocacy groups need to be strengthened throughout the state to communicate the needs of this population to lawmakers.

Development of respite care, day treatment, therapeutic foster care, crisis residential centers, and vocational centers is needed. Studies that show which residential treatment settings work best for various diagnoses will ensure appropriate care is provided at the least cost. Because of the current emphasis among private insurance on the use of inpatient hospitalization, these types of treatment often go unfunded and unused. Once insurance comapanies can be convinced of the efficacy of these types of treatment, then the funding and increased availability for them will follow.

Increased emphasis on prevention and early intervention to include targeting of high-risk families is mandatory if tertiary treatment is to be reduced. Public funding of private providers that are successful with children should also be increased. Rewarding successful programs will ensure that those programs prosper and can be duplicated elsewhere.

Private providers who offer counseling need to increase the intensity of services for this population and offer flexible scheduling and multiple locations. Most community counseling centers discussed in this chapter do not offer services to severely emotionally disturbed children but instead to less seriously disturbed children.

Studies indicating who is caring for the uninsured and what services are available to this population are needed. Regulations to provide equal access to psychiatric treatment need to be investigated. In certain states, a private corporation must pledge to provide various amounts of uncompensated care to indigent persons in order to obtain a certificate of need (Charter Medical Corporation, 1987, p. I-13). In addition, of course, the public sector needs to find ways to fund the kinds of intermediate facilities described elsewhere in this volume.

Appendix 9.1. Private Psychiatric Hospitals with Child/Adolescent Beds Licensed by the Texas Department of Mental Health and Mental Retardation

NAME OF HOSPITAL\ LICENSE NUMBER	TYPE\NO. OF PSYCHIATRIC BEDS			ORIGINAL LICENSE DATE
	Child	Adol.	drug/alcohol	
Bayview Psychiatric Hospital, #75 Corpus Christi, Tx. 78414 512-993-9700	0	28	0	07/24/86
Baywood Hospital, #70 Webster, Tx. 77598 713-332-9550	22	28	20	02/22/85
Bowling Green Hospital of San Antonio, #104 (formerly Horizon Hospital) San Antonio, Tx. 78212 512-736-2211	6	26	0	03/22/88
CPC Afton Oaks Hospital, #94 San Antonio, Tx. 78232 512-494-1060	11	11	0	05/22/87
CPC Capital Hospital, #94 Austin, Tx. 78729 512-250-8667	16	24	0	09/14/87
CPC Cypress Point Hospital, #88 Houston, Tx.77065 713-955-6550	0	22	0	04/14/87
CPC Millwood Hospital, #22 Arlington, Tx 817-261-3121	17	45	0	05/71
CPC Oak Bend Hospital, #85 Ft. Worth, Tx. 76132 817- 346-6043	16	46	0	02/17/87
Care Unit Hospital of Dallas/ Ft. Worth, #3 Ft. Worth, Tx. 76104 817-336-2828	0	0	26	09/65
The Cedars Hospital, #101 DeSoto, Tx. 75114 214-298-7323	0	14	14	01/04/88
Charter Hospital of Corpus Christi, Inc., #76 Corpus Christi, Tx. 78414 512-993-8893	8	20	0	05/20/86

Appendix 9.1 (Continued). Private Psychiatric Hospitals with Child/Adolescent Beds Licensed by the Texas Department of Mental Health and Mental Retardation

NAME OF HOSPITAL\ LICENSE NUMBER	TYPE\NO. OF PSYCHIATRIC BEDS			ORIGINAL LICENSE DATE
	Child	Adol.	drug/alcohol	
Charter Hospital of Dallas, #93 Plano, Tx. 75024 214-964-3939	8	20	0	08/17/87
Charter Hospital of Ft. Worth, #82 Ft. Worth, Tx. 76132 817-292-6844	0	20	0	11/21/86
Charter Hospital of Kingwood, #79 Kingwood, Tx. 77339 713-358-4501	10	20	0	08/22/86
Charter Hospital of Laredo, #65 Laredo, Tx. 78041 512-722-0900	0	16	0	05/15/84
Charter Hospital of Sugar Land, #78 of Sugar Land #78 Sugar Land, Tx. 77478 713-980-4000	12	32	0	08/26/86
Charter Lane Hospital, #72 Austin, Tx.78754 512-837-1800	20	30	16	01/15/86
Charter Palms Hospital, #58 McAllen, Tx. 78502 512-631-5421	8	20	12	04/18/83
Charter Plains Hospital, #62 Lubbock, Tx. 79416 806-744-5505	8	20	0	01/15/84
Charter Real, #71 San Antonio, Tx.78240 512-699-8585	0	32	0	09/15/85
Colonial Hills Hospital, #81 San Antonio, Tx. 78230 512-341-5131	14	46	0	11/24/86
Daybreak Youth Center, #111 Beaumont, Tx. 77701 409-838-6203	20	20	0	10/20/88
DePaul Center--Providence Hosptial, #66 Waco, Tx. 76712 817-776-5970	0	18	0	06/01/84

Appendix 9.1 (Continued). Private Psychiatric Hospitals with Child/Adolescent Beds Licensed by the Texas Department of Mental Health and Mental Retardation

NAME OF HOSPITAL\ LICENSE NUMBER	TYPE\NO. OF PSYCHIATRIC BEDS			ORIGINAL LICENSE DATE
	Child	Adol.	drug/alcohol	
DePelchin Children's Center/ Cullen Bayou Place, #51 Houston, Tx.77007 713-861-8136	30	17	0	10/08/81
The Devereux Foundation, #19 Victoria, Tx. 77902-2666 512-575-8271	0	84	0	07/70
Forest Springs Hospital, #107 Houston, Tx. 77090 713-893-7200	0	8	0	06/17/88
Glen Oaks Hospital, #84 Greenville, Tx. 75401 214-454-6000	0	22	0	12/23/86
Glenwood, A Psychiatric Hospital, #86 Midland, Tx. 79711 915-563-1200	6	28	0	02/06/87
Green Oaks, A Psychiatric Hospital, #61 Dallas, Tx. 75251 214-991-9504	0	56	0	10/15/83
HCA Beaumont Neurological Hospital, #14 Beaumont, Tx. 77701 409-835-4921	0	24	0	12/07/67
HCA Belle Park Hospital, #56 Houston, Tx. 77072 713-933-6000	16	83	0	10/07/82
HCA Brazos Psychiatric Hospital, #64 Waco, Tx. 76712 817-772-3500	8	32	0	04/15/84
HCA Cedar Crest, #109 Belton, Tx. 76513 817-939-2100	16	32	0	09/26/88
HCA Deer Park Hospital, #52 Deer Park, Tx. 77536 713-479-0955	0	56	0	12/01/81
HCA Greenleaf Hospital, #106 College Station, Tx. 77840 409-690-0039	0	22	0	07/30/79

Appendix 9.1 (Continued). Private Psychiatric Hospitals with Child/Adolescent Beds Licensed by the Texas Department of Mental Health and Mental Retardation

NAME OF HOSPITAL\ LICENSE NUMBER	TYPE\NO. OF PSYCHIATRIC BEDS			ORIGINAL LICENSE DATE
	Child	Adol.	drug/alcohol	
HCA Gulf Pines Hospital, #80 Hoston, Tx. 77090 713-537-0700	12	50	0	10/21/86
HCA Hill Country Hospital, #83 San Antonio, Tx. 78233 512-659-9000	0	8	8	12/03/86
HCA Houston International Hospital, #33 Houston, Tx.77030 713-795-5921	18	18	18	05/27/74
HCA Red River Hospital, #28 Wichita Falls, Tx. 76301 817-322-3171	0	14	0	10/73
HCA Richland Hospital, #87 North Richland, Tx. 76180 817-284-6411	0	28	0	03/10/87
HCA Shoal Creek Hospital, #18 Austin, Tx. 78731 512-452-0361	10	26	0	12/01/69
HCA Sun Valley Regional Hosptial, #36 El Paso, Tx. 79902-1699 915-544-4000	0	35	0	06/01/75
HCA Willow Park Hospital, #90 Plano, Tx. 75075 214-867-8670	0	20	18	12/01/87
The Haven, #10 DeSoto, Tx. 75115 214-709-3706	0	10	0	10/21/88
HealthCare Rehabilitation Center, #47 Austin, Tx. 78745 512-444-4835	21	25	0	04/23/80
Hillside Center, #42 Dallas, Tx. 75211-1655 214-330-7722	8	7	0	02/10/78
IntraCare Medical Center Hospital, #112 Houston, Tx. 77054 713-790-0949	0	14	0	12/01/88

Appendix 9.1 (Continued). Private Psychiatric Hospitals with Child/Adolescent Beds Licensed by the Texas Department of Mental Health and Mental Retardation

NAME OF HOSPITAL\ LICENSE NUMBER	TYPE\NO. OF PSYCHIATRIC BEDS Child	Adol.	drug/alcohol	ORIGINAL LICENSE DATE
Laurel Ridge, A Brown Schools Psychiatric Hospital, #95 San Antonio, Tx. 78247 512-494-0713	32	96	0	09/15/87
Laurelwood Hospital, #49 The Woodlands, Tx. 77387 713-367-4422	16	22	22	08/03/81
Live Oak Hospital, #73 Victoria, Tx. 77904 512-576-0814	0	16	16	03/05/86
Meridell Achievement Center, Inc. Westwood Campus, #57 Liberty Hill, Tx. 78642 512-259-3807	50	0	0	09/27/82
Meridell Achievement Center, Inc. Windridge (Main) Campus, #77 Austin, Tx. 78766-9383 512-258-1691	48	0	0	09/27/82
Methodist Home Children's Guidance Center, #23 Waco, Tx. 76708 817-753-0181, ext. 278	11	11	0	07/71
The Oaks Treatment Center, #26 Austin, Tx. 78745 512-444-9561	0	120	0	02/24/72
Orchard Creek Hospital, #74 Rosenberg, TX. 77471 713-342-0010	0	24	0	03/05/86
Pinelands Hospital, #91 Nacogdoches, Tx. 75961 409-560-5900	0	12	0	06/01/87
Psychiatric Institute of Ft. Worth Ft. Worth, Tx. 76104 817-335-4040	16	99	0	05/14/74
Psychiatric Pavilion of Amarillo Hospital District, #11 Amarillo, Tx. 79106 806-378-4510	0	20	0	07/67

Appendix 9.1 (Continued). Private Psychiatric Hospitals with Child/Adolescent Beds Licensed by the Texas Department of Mental Health and Mental Retardation

NAME OF HOSPITAL\ LICENSE NUMBER	TYPE\NO. OF PSYCHIATRIC BEDS Child	Adol.	drug/alcohol	ORIGINAL LICENSE DATE
River Crest Hospital, #100 San Angelo, Tx. 76901-5016 915-949-5722	0	22	0	12/22/87
St. Joseph Hospital, #10 Houston, Tx. 77002 713-757-1000	0	18	0	09/66
San Marcos Treatment Center, #46 San Marcos, Tx. 78667-0768 512-396-8500	0	129	0	04/23/80
Southwest Neuropsychiatric Institute Woodlawn Campus, #38 San Antonio, Tx. 78228 512-736-4273	42	42	0	11/26/75
Southwest Neuropsychiatric Institute Medical Center Campus, #102 San Antonio, Tx. 78229 512-696-9977	16	16	0	01/26/88
Spring Shadows Glen, #48 Houston, Tx. 77080 713-939-5711	0	40	0	04/15/81
Stafford Meadows, #105 Stafford, Tx. 77477 713-240-2626	0	22	0	04/14/88
Tarrant County Psychiatric Center, #92 Ft. Worth, Tx. 76104 817-923-6467	0	20	0	10/12/87
Timberlawn Psychiatric Center, #2 Dallas, Tx. 75228 214-381-7181	20	40	0	19/57
Twin Lakes Hospital, #97 Denton, Tx. 76201 817-383-4660	0	32	0	10/30/87
University Park Hospital, #69 Tyler, Tx. 75701 214-566-8666	0	16	0	02/27/85
Villa Rosa Psychiatric Hospital, #102 San Antonio, Tx. 78229 512-697-6020	0	24	0	03/22/88

Appendix 9.1 (Continued). Private Psychiatric Hospitals with Child/Adolescent Beds Licensed by the Texas Department of Mental Health and Mental Retardation

NAME OF HOSPITAL\ LICENSE NUMBER	TYPE\NO. OF PSYCHIATRIC BEDS Child	Adol.	drug/alcohol	ORIGINAL LICENSE DATE
West Oaks, The Psychiatric Institute of Houston, #50 Houston, Tx. 77074 713-995-0909	16	32	0	09/01/81
West Oaks at Cypress Creek, A Psychiatric Hospital, #99 Houston, Tx. 77090 713-586-7600	14	16	0	01/05/88
Westheimer Estates Hospital, #98 Houston, Tx. 77057 713-780-1229	0	4	0	11/13/87
Willow Creek Adolescent Center, #67 Arlington, TX. 76017 817-572-3355	0	56	0	12/05/84
Willowbrook Hospital, #96 Waxachie, TX. 75165 214-923-0254	8	18	0	08/11/87
Woods Psychiatric Institute, #53 Abilene, Tx. 79608 915-698-2320	64 combined		0	09/15/84

total # beds licensed: 3108
total # facilities licensed: 76

Source: TDMHMR, 1988a.

References

Blevins, T. 1989. Executive Director, Lena Pope Children's Home, Ft. Worth, Tex. Interview, November 7.

Carpenter, K. 1990. Statistician, Texas Department of Human Services, Austin, Tex. Telephone interview, April 4.

Charter Medical Corporation. 1987. Annual Report of Charter Medical Corporation. Atlanta, Georgia.

"Committed Youth," 1989. Newsweek (July 31).

CPC. 1988. Community Psychiatric Centers Annual Report. Wilmington, Delaware.

Crumpton, Laurie, Chandler Stolp, and David C. Warner. 1989. Hospital Care for Schizophrenia in California in 1984. Working Paper Number 54. Lyndon B. Johnson School of Public Affairs. Austin, Texas.

Dorwart, Robert, and Mark Schlesinger. 1988. "Privatization of Psychiatric Services." American Journal of Psychiatry, Vol. 145, pp. 543-553.

Kamerman, S. B., and A. J. Kahn. 1989. Social Services for Children, Youth and Families in the United States. New York: Annie E. Casey Foundation.

Lyman, R. L., S. Prentice-Dunn, and S. Gabel. 1989. Residential and Inpatient Treatment of Children and Adolescents. New York: Plenum Press.

McElrath, R. L. 1984. "Evaluation of Hope Center for Youth." Professional report, LBJ School of Public Affairs, University of Texas at Austin.

Melton, G. 1984. Service Models in Child and Adolescent Mental Health: What Works for Whom? University of Nebraska Press. Lincoln, Nebraska.

"Mental Health Business Scrutinized for Ad Blitz." 1989. Dallas Morning News (Sept. 5).

National Institute of Mental Health. 1989. "Expenditures by Mental Health Organizations, United States, 1969-1981." Mental Health Statistical Note No. 170. Washington, D.C.: U.S. Government Printing Office.

____________. August 1985. "Residential Treatment Centers for Emotionally Disturbed Children, United States, 1977-1978." Mental Health Statistical Note No. 162. Washington, D.C.: U.S. Government Printing Office.

Phillips, Irving. 1990. "Trends in the Delivery of Mental Health Services for Children and Adolescents". Bulletin of the Menninger Clinic, vol. 54, pp. 95-102.

Regional Network for Children. 1987. A Manual for Resources for Children. Austin, Tex.

Relman, Arnold S. 1980. "The New Medical-Industrial Complex." New England Journal of Medicine, vol. 303, pp. 963-970.

Schlesinger, Mark, and Robert Dorwart. 1984. "Ownership and Mental-Health Services, a Reappraisal of the Shift toward Privately Owned Facilities." New England Journal of Medicine, vol. 311, pp. 959-965.

Stroul, Beth A., and Robert M. Friedman. 1986. *A System of Care for Severely Emotionally Disturbed Children & Youth*. Washington, D.C.: CASSP Technical Assistance.

Stroul, Beth A. 1988. *Community-Based Services for Children & Adolescents Who Are Severely Emotionally Disturbed: Home-Based Services*. Washington, D.C.: CASSP Technical Center.

Sutton, Beverly. 1989. "Psychiatric Hospitalization of Children and Adolescents." (Draft.) Texas Department of Health/ American Hospital Association/ Texas Hospital Association Survey. 1988. "Annual Survey of Hospitals." Austin, Texas.

Texas Department of Human Services. January 1989. *DHS Overview*. Austin, Texas.

____________. June 1988. *Protective Services for Families and Children: Annual Report Fiscal Year 1987*. Austin, Texas.

____________. 1987. *Consolidated Standards for 24-Hour Child Care Facilities: Institutions Providing Basic Child Care, Institutions Serving Mentally Retarded Children, Residential Treatment Centers, Halfway houses, Therapeutic Camps*. Austin, Texas.

____________. February 1980. *Minimum Standards: Foster Family Homes*. Austin, Texas.

Texas Department of Mental Health and Mental Retardation. November 1988. "Texas Psychiatrist Survey." Austin, Texas. (Draft.)

____________. 1988a. "Private Mental Hospitals Licensed by TDMHMR." Austin, Texas. (December 23.)

Texas Department of Mental Health and Mental Retardation and Texas Department of Human Services. January 1989. *Child Abuse and Neglect: The Impact on Texas Children, Families, and Communities and the Need for Treatment Services*. Report to the 71st Legislature. Austin, Texas.

Texas Health and Human Services Coordinating Council. February 1989. *Children and Youth in Texas: A Proposal for Coordinated Services*. Austin, Texas.

Texas Mental Health and Mental Retardation Act. June 1980. Art. 5547-201, sec. 1.01. Revised.

Texas Network for Children, Youth, and Families. 1989. TNCinfo2.0. Austin, Texas. (Computer program.)

Turner, M. R. 1988. *The Emerging Role of Residential Treatment Centers in the Psychiatric Treatment of Emotionally Disturbed Children*. University of Texas Press, Austin, Texas.

U. S. Congress, Office of Technology Assessment (OTA). December 1986. *Children's Mental Health: Problems and Services--A Background Paper*. Washington, D.C.: U.S. Government Printing Office.

Weithorn, Lois. 1988. "Mental Hospitalization of Troublesome Youth: An Analysis of Skyrocketing Admission Rates." *Stanford Law Review*, vol. 40 (February).

Weizanbaum, Jon. 1989. Caseworker, Casey Family Services, Austin, Tex. Interview, December 4.

Chapter 10. Mental Health Insurance Coverage and its Impact on Financing Care for SED Youth in Texas

The nature of insurance coverage as it relates to financing care for severely emotionally disturbed children is an area of great concern nationwide and in Texas. Few would argue that the various systems of mental health care coverage are adequate at either level. This chapter will address some problems associated with mental health care coverage for youth and explore possibiiities for change. While not solely confined to Texas, the discussion will identify where the problems exist and offer some potential solutions.

MENTAL HEALTH COVERAGE AND SED YOUTH

This section will review national and state data concerning current trends in insurance for mental health benefits. Additionally, insurance for SED youth will be investigated. Finally, the costs of services will be discussed.

National Trends in Mental Health Coverage

Insurance coverage for mental illness has continued to expand in recent years. Many factors contribute to this increase. Most states now have some sort of mandated insurance coverage (Sharfstein, 1989, p. 688). Additionally, mental illness has become more socially acceptable and health care consumers feel freer to pursue psychiatric services (Dorwart and Schlesinger, 1988, p. 546).

A survey conducted by the International Foundation of Employee Benefit Plans found that 95 percent of the respondents indicated that their health insurance included mental health benefits. Of these respondents, 68 percent considered these benefits very important. In addition to hospitalization, half of the respondents reported that outpatient services were also offered. These generally consisted of 20 sessions of therapy with a 50 percent maximum copayment (La Sota, 1988, p. 23). Though these figures indicate that psychiatric health care is available for the insured, there is little evidence that suggests these types of coverages are adequate or effective. Limits on lifetime coverage, high deductibles, and co-insurance may hinder access to care. Insurance design can also influence the types of services offered. Often this tends to bias care toward hospitalization and away from community-based services.

Insurance coverage for inpatient mental health care in most group health plans like Blue Cross and Blue Shield generally contains a lifetime limit of between $10,000 and $50,000; the most common level chosen by employers is between $10,000 and $20,000 (Coleman, Interview, January 29, 1990). In the past, funding for inpatient coverage for mental health services appears to have been adequate for the insured and eligible dependents (Coleman, 1989). However, this type of coverage arrangement results in many private insurance dollars being available for inpatient coverage and often few, if any, of them available for less restrictive and often cheaper means of care.

Most commonly, insurance companies pay for outpatient treatments at a lower level than inpatient treatment (Craig, 1988). Outpatient mental health coverage is generally characterized as having a per-visit maximum charge with a minimum copayment. Generally outpatient coverage is capped at between $1,000 and $1,500 yearly with a lifetime limit of approximately $20,000 (Coleman, 1989). Most outpatient funding goes for periodic visits to the psychiatrist, with little of the funding going for in-home family therapy or other less restrictive means of care. In fact, there is a dearth of community-based services, case management, coordination, and support for nonhospital treatment (Saxe, Cross, and Silverman, 1988, p. 900).

Figure 10.1 provides data on the Texas population of health insurers and the benefit delivery system they employ. In a survey done by the Texas State Board of Insurance, 94 percent of group policies provided for psychiatric hospitalization. Deductibles were the same as any other illness, ranging from $100 to $500. The majority of the respondents indicated that co-insurance requirements were 20 percent for inpatient and 50 percent for outpatient (Texas State Board of Insurance, 1987). During the proceedings of a Texas Senate Interim Committee meeting addressing psychiatric hospitalization of children, the following information was given in testimonty:

1. Most employer health benefit plans are designed to favor coverage for inpatient mental health services and are designed to provide fewer benefits for less restrictive outpatient care.

2. Insurance coverage for mental health service is most often characterized by policies which offer more dollars for inpatient care than outpatient care.

3. Coverage provided for inpatient mental health care is most often limited to between $10,000 and $50,000 lifetime benefits with the most common lifetime level chosen between $10,000 and $20,000.

4. Coverage for outpatient mental health care is most often characterized by a $1,000 to $1,500 yearly limit with a $20,000 lifetime limit.

5. Inpatient mental health care is paid for on 20 percent co-payment.

6. Outpatient care is most often characterized by a system of copayments and/or deductibles. Most often, plans utilize copayments with maximum allowable per-visit limits. Most of the time the copayment level is between 50 percent and 20 percent.

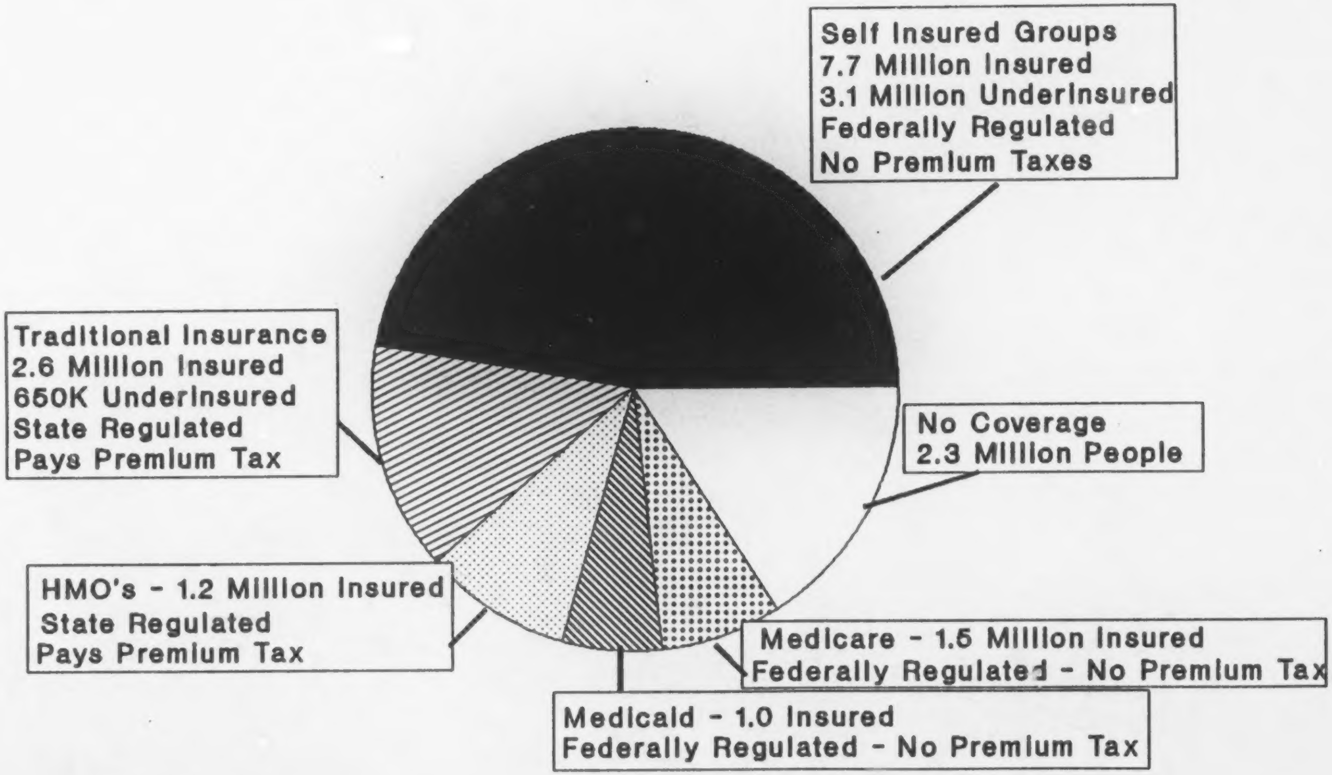
7. Some employee health benefit plans stipulate caps on the number of outpatient visits permitted in addition to copayment and maximum benefit requirements. The visit caps are generally in the 20-per-year range and sometimes there are a specified number of lifetime visits. (Texas Senate Interim Committee, 1989)

Uninsured Youth

The Office of Technology Assessment's report of July 1989 on adolescent health insurance gives an overall picture of the characteristics of youth who are uninsured or underinsured. Most of the time, the problems of uninsured adolescents are a direct result of the problems of their uninsured parents (U.S. Congress, OTA, 1989, p. 1). Most adolescents aged 10 to 18 live with their parents and rely on their parents for health insurance coverage. Insurance for adolescents is dependent on the ability and willingness of parents to provide such coverage. Often, traditional insurance plans cannot and do not meet the long-term mental health needs of children.

Of all adolescents in the United States aged 10 to 18, approximately 4.6 million or 15 percent were without public or private health insurance coverage in 1987 (U.S. Congress, OTA, p. 6). Adolescents of this age group were more likely to be uninsured than younger children and adults aged 25 to 54. Twelve percent of all adolescents live with uninsured parents and almost two out of three uninsured adolescents live with parents who are also uninsured. Family income is the most important determinant of health insurance status for all age groups of children. Poor or low-income families are much more likely to be

Figure 10.1. Health Insurance Coverage In Texas*



Source: Coleman, 1989.

* Based on Population Estimate of 17 Million

uninsured than others. Forty-one percent of uninsured adolescents live below the federal poverty level, roughly one-third are between 100 and 199 percent of poverty, and about one-quarter are at 200 percent of poverty or above (U.S. Congress, OTA, 1989, p. 6).

Forty-three percent of Hispanic adolescents, 30 percent of whites, and 26 percent of blacks are uninsured in families with incomes below 150 percent of poverty (U.S. Congress, OTA, 1989, p. 6). Adolescents who live with two parents are more likely to be insured than others. This statistic, however, is strongly correlated with family income because many adolescents living with one parent (mother) are below 150 percent of poverty. In terms of parent education and income, adolescents at each family income level whose parents have little or no education are much more likely to be uninsured than adolescents who have greater family incomes or more education (U.S. Congress, OTA, 1989, p. 6).

Using per capita income as a predictor of health insurance coverage, it is estimated that in Texas, which has the same per capita income as the national average, 15 percent of youth are uninsured. Based on 1985 population figures for the state it is expected that some 719,000 youth were without insurance coverage in the state (U.S. Congress OTA, 1989).

Specialized, appropriate mental health services for children have only recently been the focus of attention in this state. Consequently, comprehensive data about the types of services beneficial to these children are scarce. In 1988, it was estimated by the Texas Department of Mental Health and Mental Retardation that 60 percent (150,802) of all SED youth in Texas received mental health services from the private sector (September 1989, p. 64). Of the 100,534 youth who were expected to require services from the public sector, approximately 21 percent (22,000) received them (TDMHMR, September 1989, p.64).

The proposals for reducing the problem of the uninsured and underinsurance for youth have been rather limited. Employer mandates and relaxed categorical requirements for Medicaid have both been suggested as ways to help reduce this problem. The Office of Technology Assessment estimated that if health insurance were required for employees who worked 30 hours or more per week, approximately 2.55 million of the uninsured adolescent population (55 percent) would become insured. The study further indicated that as the hour thresholds for full-time employment were lowered, additional numbers of previously uninsured adolescents would become insured (U.S. Congress, OTA, 1989).

Costs of Insurance Coverage

The system of mental health coverage benefits, as it relates to children and adolescents, is often problematic. Generally, when one thinks of mental health services, there is an automatic tendency to focus on inpatient hospital care or some type of residential program. Hospitals are often relied upon, particularly nonpublic facilities, because insurance pays for hospitalization but not for sufficient outpatient treatment or nonmedical forms of residential care (Saxe, Cross, and Silverman, 1988, p. 805). Many believe that inpatient care is appropriate only in cases of crisis intervention and real recognized chronic and profound mental disorders (Behar, Interview, November 9, 1989). Since typically there are no separate mental health benefit provisions for children within group health plans, it may indeed be true that the benefits they receive are not designed according to their needs. Consequently, and in many cases children and adolescents are doomed to flipping in and out of treatment facilities simply because the proper services were not available to them in the early stages of their problem (Behar, Interview, November 9, 1989).

Perhaps the most compelling set of remedies to this problem is through less reliance on the system of private insurance and more reliance on good public programs. The coverages provided through traditional insurance plans are most often inadequate and costs for services covered by private insurance are high. Access to appropriate care in the public sector can serve the twofold function of providing more long-lasting results as well as helping prevent the trend toward exhausting insurance coverage policy limitations in the first 30 days of treatment.

Health care costs now consume 11 percent of the gross national product. One of the factors involved in this is the increase in the use of hospitalizations (Scharfstein, 1985, p. 24). Mental health and substance abuse costs are rising faster than the costs of other types of health care. In 1989 mental health costs rose an estimated 57 percent (Priest, 1990). Indeed for the average employer, 15 to 25 percent of total health care costs are for mental health care. These costs are rising faster than any other component of the medical plan and represented $244 per employee in 1989, up 18 percent over the 1988 figure (Adler, 1990b, p. 28).

Additionally, costs associated with insured mental health care for children are rising at an astronomical rate due to the enormous increase in psychiatric hospitalization rates for adolescents. Between 1984 and 1988 admissions of adolescents rose 450 percent (Adler, 1990b, p. 28). Benefit consultants believe that people are being falsely convinced that children need expensive inpatient care (Adler, 1990b, p. 28).

Another factor leading to higher mental health costs in Texas is a result of legislation in 1989. S.B. 911 mandates that chemical dependency or addiction must now be covered in insured risk benefit group health plans. The most common type of treatment for this problem is a 30-day inpatient rehabilitation service.

Spiraling health care costs, including mental health services, have contributed to the high levels of health insurance premiums. Overall, health insurance premiums rose by 12 percent between 1987 and 1988. This represents a near doubling in the rate increase from 1986 to 1987 (Health Insurance Association of America, July 1989, p. 2). It is predicted that 1989 and 1990 will also be years of substantial increased costs for premiums (Health Insurance Association of America, July 1989, p. 20).

In Texas, insurance companies and employers are concerned about the costs of mental health benefits. Parents are concerned about the appropriateness of care for their children. As a result, the Texas Senate has created a special committee to study the problem. In its first meeting, the Ad-hoc Committee on Psychiatric Hospitalization of Children adopted the following charges:

1. Identify barriers to receipt of appropriate services by children and adolescents.
2. If overhospitalization of children does exist, identify its causes.
3. Review advertising and patient recruitment techniques used by psychiatric facilities serving children and adolescents.
4. Identify gaps in the child and adolescent mental health service delivery system.
5. Identify ways that may improve access to mental health services for children and adolescents. (Texas Senate, Interim Committee, 1989)

To help control costs, many advocate that the insured needs to be given the flexibility to choose what type of care is to be administered rather than force-feeding inpatient care in every circumstance. All too often, the typical 30-day stint for the emotionally disturbed child drains or substantially depletes the available private insurance funds. Shifting the emphasis from costly inpatient treatment to outpatient treatment may very well act to save insurance dollars and provide better and more appropriate care for the child in less restrictive settings.

Why don't insurance companies and employers opt for outpatient services? It may be that with the high costs of mental health services, insurance companies are concerned with benefits being used for discretionary rather than medical treatment. These include services such as marriage counseling, smoking cessation programs, and stress clinics (Texas State Board of Insurance, 1987, p. 20). Perhaps employers choose greater inpatient coverage plans to deal with psychiatric emergencies instead of what they feel is often subjective and unneeded use of outpatient coverage.

OVERSIGHT MECHANISMS INVOLVING MENTAL HEALTH CARE

With the increase in psychiatric hospitalization of adolescents, criteria are needed for determining when inpatient care is appropriate. Many third-party payers are now utilizing oversight mechanisms to ensure that services are cost effective and appropriate.

Managed care is any arrangement or system in which there are financial, administrative, organizational, and monitoring constructs whose end is to maximize efficiency and quality (Rodriguez, 1989, p. 11). These arrangements involving mental health services are governed by two factors: the need to ensure that care of adequate quality is being received for the insurance dollars spent and the attempt to contain costs of overutilization and overhospitalization by ensuring that services are appropriate. In this section preauthorization, utilization review, direct contracting, benefit design, and employee assistance programs will be discussed.

Preauthorization

If done correctly and without undue delay, the system of preauthorization for mental health services has the potential to contain costs and ensure that rates remain affordable and treatment appropriate. Given that psychiatric illness or the perception of such illness is a quite subjective matter, preauthorization of mental health services is needed. It not only helps prevent overutilization and unwarranted care, but also acts to ensure that the quality and appropriateness of psychiatric care is what it should be. With the advent of selective provider contracts, like PPOs and HMOs, true preauthorization can be done. This happens because the precertifiers are doctors who screen the cases. With the doctor being the agent, on-the-spot determinations can be made regardless of the nature of the mental health service in question. Such systems of preauthorization could work equally as well in less restrictive systems of care for children and adults (Howard, 1989, p. 18).

Preauthorization of mental health care not only allows insurers to contain costs, it also provides an opportunity to collect information on the insured. By providing data on what services are most appropriate for children and adolescents, it may be possible to compile empirical evidence suggesting which type of care (inpatient or outpatient) demonstrates the best results. These data may support the theory that less restrictive mental health care may be more appropriate and cost effective for children.

Preauthorization can be done by agencies outside of the insurance company. An example of this is the Texas Medical Foundation (TMF). The TMF is a private, for-profit organization which performs peer review and preauthorzation services for its member clients. These clients are either directly involved or involved as third parties in the administration of health care benefits. The TMF provides preadmission review and concurrent review for inpatient psychiatric care. These reviews often include care received by SED children (Martin, Interview, December 19, 1989).

Utilization Review

Systems of utilization review (UR) can be cost effective in the delivery of mental health care by reducing the length of stay and preventing overutilization. In order to be effective, a UR plan should be done early in the course of mental health treatment. It should result in denial and appeal rates of less than 1 percent and be based on education and persuasion rather than assigning lengths of stay (Howard, 1989, p. 18). Although cutting admissions by less than 1 percent may seem quite small, the aggregate effect of effective UR can substantially curtail abuse and misuse of the system. Some think that utilization review alone can do little to affect overadmissions since roughly 90 percent of psychiatric admissions are considered emergencies. Since the UR firms are often contacted 24 to 48 hours after the admission, true precertification is often impossible (Howard, 1989, p. 18).

Direct Contracting

The concept of direct contracting for mental health services utilizes some of the fundamental ideas behind the establishment of PPOs and HMOs and takes them a bit further. This idea is based on the concept of returning to private enterprise on a person-to-person level (Bradman, 1989, p. 50). Direct contracting involves employers, insurers, and other third-party payers to negotiate directly with community-based private practices. Often, communities have mental health resources that can accommodate employer plans at a substantially lower cost and higher quality than many HMOs or PPOs. Because of the nature of funding under traditional group health insurance plans, children and adolescents are often unable to receive any outpatient or less restrictive treatment which might be available in the community. When the quality of care is good, direct contracting in the community for mental health services can yield lower costs to payers and convenient community-based care for patients. Many also argue that if given the freedom of choice, individuals would choose these community resources anyway (Bradman, 1989, p. 50).

Benefit Design

Perhaps the most important determinant to adequate mental health insurance coverage is benefit design. For example, the Office of Technology Assessment concluded in a recent study that inpatient and outpatient treatment programs are equivalent in effect while the costs associated with them are notably different. A 28-day inpatient substance abuse program averaged $10,000 to $12,000, while the outpatient program averaged $1,500 to $2,000 (Howard, 1989, p. 19).

The impetus, then, would be to design benefits which effectively relocate treatment to outpatient programs both for cost and quality control. For this to succeed, however, insurance companies must provide adequate outpatient benefits.

Another important and practical benefit design change is to combine mental health care and substance abuse coverages into one package. Having two separate benefit coverages can lead health providers to switch a diagnosis from substance abuse to psychiatric when the substance abuse benefit is about to be exhausted and vice- versa (Howard, 1989, p. 19). It should be noted that S.B. 911 from the 71st Legislature, requiring that substance abuse be covered as any other illness, may serve to exacerbate the problem of switching diagnoses since the language would seem to make it difficult for insurers to combine substance abuse and mental health benefits.

Another aspect of benefit design is "carving out" mental health benefits into completely separate insurance benefit plans. Among Fortune 500 companies at least half have gone to stand-alone mental health care benefits in the last five years (Adler, 1990a, p. 27). Experts contend and data suggest that psychiatric and substance abuse costs can be cut

10 to 40 percent by managing these benefits separately (Adler, 1990a, p. 27). The cost savings due to "carving out" are a result of firms being able to hire specialized psychiatric utilization review firms, changing plan design, and creating networks of mental health professionals through managed care (Adler, 1990a, p. 27).

While cost containment is certainly one important factor in the "carve out" equation, improvements in care are also evidenced. Advocates of the "carve out" programs contend that by hiring specialty UR firms they are able to match the employees' needs with a wide array of treatment options, including (1) individual and group psychotherapy, (2) day treatment programs, (3) acute residential treatment, (4) transitional residential treatment programs, (5) outpatient care, (6) partial hospitalization, and (7) inpatient care (Adler, 1990a, pp. 27-28). One could envision another separate mental health benefit "carve out" for the treatment of dependent children of covered employees. Perhaps such a "carve out" plan for children could offer benefits patterned after the continuum of care most appropriate for youth with mental health problems.

Employee Assistance Programs (EAPs)

These types of programs are generally set up by employers who are interested in the prevention of health problems and are often offered to employees at little or no cost in addition to their regular health insurance coverage. The EAP allows employers to offer in-house services to augment their existing health insurance plans. Some argue that expanding the traditional preventative roles of EAPs to include the power to run comprehensive mental health and substance abuse programs is the long-range solution to insurance funding problems (Bradman, 1989, p. 50). EAPs may be the best way to treat the emotionally disturbed child because of their ability to better focus on the child's problem as it fits into the context of the family as a unit.

A MODEL PROGRAM: THE FORT BRAGG PROJECT

Approximately four years ago in the area of Fort Bragg, North Carolina, a pilot project began based on a model of a less restrictive continuum of care. This plan was developed by the North Carolina Department of Human Services. At that time there had been an impetus to provide a full continuum of care as a result of the increased political focus on SED children brought about by the Willie M lawsuit. Traditionally, comprehensive mental health services for children had existed only in a highly restrictive hospital setting. Very few outpatient services were offered. The project was developed through the concept that less restrictive family and community-oriented care for severely emotionally disturbed children is more appropriate than traditional means of care. Treatment plans were developed which offered "mid-range services," so called because they offered comprehensive care in the community. These services were provided by multiple public agencies who collaborated to provide appropriate treatment in an appropriate setting. These services included case management, in-school support services, therapeutic preschool, therapeutic vocational placement, day treatment, evening treatment (after school or work), therapeutic camping, family support, and in-home crisis stabilization.

The public program was very successful and expanded its services. At the nearby Fort Bragg Military Reservation, which includes Pope Air Force Base, there were approximately 43,000 children and adolescents who are covered by the federal CHAMPUS insurance plan. Of this population of 43,000, it was estimated that approximately 2.5 percent or roughly 1,200 would require services as severely emotionally disturbed children (Behar, Interview. November 9, 1989). Because the less restrictive continuum of care program was so successful in the public sector, a rather unique proposal and subsequent accord was developed. The director of the continuum of care project approached the CHAMPUS provider with a contract proposal whereby the state system of care would become the exclusive provider of psychiatric and mental health services for children and adolescents covered under the CHAMPUS plan in the Fort Bragg area. The main idea behind the proposal was that the state continuum of care could provide services which were less expensive and more appropriate than services offered by private providers. Since CHAMPUS representatives estimated that approximately $4 million would be spent on mental health care for military dependent children in 1989, this became the target figure under the contract arrangement (Behar, Interview, November 9, 1989).

After some deliberation, a 52-month contract was signed between CHAMPUS and the North Carolina Department of Human Services which stipulated that the state system of care would be the Exclusive Provider Organization (EPO) for the military dependent children in the Fort Bragg area. The project was scheduled to get underway on May 1, 1990, and is the culmination of some four years of planning (Behar, Interview, November 11, 1989).

It is hoped that the type of arrangement that has come about in the Fort Bragg area will also allow the opportunity for extensive case analysis, data collection, and follow up on the results of this project. The project has allocated, as part of its budget, extensive follow-up and case analysis plans in order to determine the effectiveness of the program. The data collected will likely be the litmus test by which other less restrictive continua of care systems will be judged (Behar, Interview, November 9, 1989).

If successful, there is reason to believe that this type of arrangement could be extended to other parts of the country which have similarly effective, less restrictive care systems. Success of transferability will depend on the effectiveness of the pilot program being offered, appropriate media attention, and the willingness of employers and insurance companies to accept alternative systems of care as viable and superior. Projects, seminars, news conferences, and other high-profile efforts are needed to educate decision makers on the merits of less restrictive care settings for children and adolescents. One of the potential problems with transferability, however, is that the population of covered children is seldom as concentrated and homogeneous as it is in the Fort Bragg area. This fact may greatly limit the extent to which this type of arrangement may be transferred.

ISSUES, CONCERNS, AND PROBLEMS SPECIFIC TO TEXAS

With the lack of comprehensive data about appropriate services for SED children, it is difficult to speak about perceived problems. What has been shown on the national level can give some indication of the issues which will need to be addressed. The most severe of the documented problems is the degree of uninsured and underinsured youth. Costs of health insurance are high and getting higher. Adding dependent children benefit plans is expensive. This cost may be creating an ever-growing population of uninsured children in this state. Blue Cross/Blue Shield of Texas provides statistics showing that the average number of insureds per written contract has gone from around 2.5 in 1988 to less than 2 in 1989. Many feel this type of statistic is an indication that insurance for dependent family members, including children, is becoming prohibitively expensive. (Coleman, Interview, January 29, 1990).

In this state, the mentally ill have chronically been underserved. The R. A. J. v. Miller lawsuit against the Texas Department of Mental Health and Mental Retardation mandated that adequate and appropriate services be provided to the mentally ill. Children's needs for mental health services have only recently been addressed. Public funding as an answer for those who cannot afford insurance has not been realized and remains largely inadequate (TDMHMR, 1989, p. 83).

In order to adequately address the funding problem, data are needed describing the mental health needs and resources for youth in Texas. This type of factual information would include studies on mental health insurance benefits for dependent children .

Additionally, extensive longitudinal studies are needed with outcome results of different treatment modalities. Currently, the provision of services for SED youth is inadequate, both within the public and private sectors. Services for those with private insurance appear to be in place, but it is often inappropriate and unnecessarily expensive. While some good programs exist in the public sector, funding for them and others is grossly inadequate.

Another concern in Texas is the availability of funding for outpatient services. Cost containment influences the degree of insurance coverage for such care. This is due in large part to the many differing methods of treatment which exist (Howard, Interview, January 26, 1990). Although studies have shown that less restrictive outpatient settings are often more appropriate for children and adolescents, similar data are lacking in the area of cost containment. This lack of data lends credence to insurance providers' concerns about the cost effectiveness of less restrictive outpatient care.

Another area of concern is the overhospitalization of youth within private psychiatric hospitals. Inpatient services are big business within the private sector. In fact, nearly half of Texas' private psychiatric hospitals have opened in just the past three years (Rubin, 1989, p. A1). Part of this problem is that insurance benefits are tailored in such a way that they fit the scheme of care being offered in these facilities. Additionally, there are no third-party-imposed constraints on pricing for psychiatric services as there are in the medical/surgical area (Lewis, 1989, p. 135).

Currently, it is questionable whether innovative, appropriate care is available in the public sector. The CASSP initiative is just now getting underway in this state and may well prove to encourage development of insurable and cost-containable methods of treatment for children and their families. Other pilot programs within TDMHMR show a great deal of promise by providing an alternative to hospitalization.

Finally, parents of children who need mental health services often lack the expertise to decide which treatment modalities are appropriate for their children. Increasing public awareness about mental illness will help promote the facts and dispel the myths about SED youth.

Out of these general concerns come several specific problems that need the attention of policymakers and others. First and perhaps foremost, most insurance benefits do not adequately cover less restrictive types of psychiatric services for children. Until this happens, families will not avail themselves of this type of treatment. This leads to the issue of whether or not children are receiving appropriate services (Texas Senate Interim Committee, 1989).

Another specific problem is that even though outpatient psychiatric care may actually be more effective and less expensive for the treatment of children, it has not been adequately demonstrated that predictable mechanisms for cost containment exist. The Fort Bragg project discussed earlier is one of the first major attempts to prove that the less restrictive kinds of care are appropriate and cost effective.

The problems of drug and substance abuse greatly exacerbate the inherent problems of insurance funding for SED youth. As discussed earlier, recent legislation mandates that insurance plans treat chemical dependency as "any other illness." This puts a great deal of strain on an already weak health insurance system. Insurers complain, perhaps rightfully so, that the problem of substance abuse is so prevalent in children and adolescents that mandated coverage is beyond the scope of traditional insurance and such treatment will act to detract from other coverages for children including mental health (Texas Senate Interim Committee, 1989).

Another problem in Texas is the lack of integration between public and private mental health care. Once a child's insurance runs out, after episodes of costly inpatient treatment, the burden of responsibility to provide care falls upon the public sector. If proactive treatment planning is developed by collaboration between the private and public sectors, perhaps children will have more comprehensive, less costly services.

A final problem concerns the design of insurance benefits themselves. Individuals choosing and designing mental health benefits are often unaware of more effective, less costly breakthroughs in psychiatric care for children. This unfamiliarity with programs, other than the traditional array of benefits, could be resolved with efforts directed at public relations and education (Texas Senate Interim Committee, 1989).

RECOMMENDATIONS

The issues concerning insurance coverage for mental health benefits for children in Texas is a very complex problem. This section will provide some information and plans of action addressing the concerns and problems outlined previously.

Through effective demonstration, insurers must be shown that less restrictive continua of care are appropriate and cost-containable alternatives. By demonstrating that this type of care lends itself to some measure of predictability, insurance coverage may begin to reflect more flexible coverages for mental health benefits.

A second important recommendation is that facilities which utilize a less restrictive continuum of care take an active role in the education of insurers about the merits of this type of treatment. Efforts of direct contracting with communities, insurance companies, and businesses may well prove to showcase the fact that this type of treatment for children is more effective and cost containable than the present system.

Integration efforts between the public and private sectors must be undertaken. Such integration would involve coordination among insurance companies, private hospitals, and public-sector programs. In other words increases would pay for private care but might also subsidize development of public, less restrictive, alternatives at savings to the patient and the public-sector while helping underwrite more effective care for all.

Programs like Ft. Bragg, which encourage mental health services within the public sector, may prove to be one solution to funding problems for SED youth. Placing more trust in good public programs and garnering more federal money for public assistance may serve to utilize private and public dollars for less restrictive care modalities.

Awareness and communication are other important factors in making positive changes in Texas. Insurers and others must come to realize that the mental health care needs of children are unique--not only unique as a class but unique to each individual child. A wide array of treatments are needed for children's services. Additionally, reform of the oversight mechanisms of preauthorization should include appropriateness of mental health care, assessing both inpatient and outpatient treatment modalities.

A final recommendation is that Texas must adopt new policies enabling more children and adolescents to be covered for health care benefits. Clearly the "crazy-quilt" arrangement between the public and private sectors, coupled with the number of children who go without proper services, begs immediate reform. Whether through private or public funding sources, Texas must seriously consider implementing plans whereby children and adolescents are able to access mental health services.

References

Adler, Stacey. 1990a. "Mental Health Benefits Revised: Advocates of Carving Out See Savings, Better Quality." Business Insurance (February 19), pp. 27-28.

Adler, Stacey. 1990b. "Psychiatric Costs Rising at Large Firms." Business Insurance (February 19), p. 28.

Behar, Lenore. 1989. Director, North Carolina Department of Human Services, Fort Bragg, North Carolina, Telephone interview, November 9.

Bradman, Leo H. 1989. "Contract Directly for Mental Health Care." Business Insurance (October 16).

Coleman, Rogers. 1989. "Statement Before the Ad-Hoc Committee on Psychiatric Hospitalization of Children." Austin Mental Health Association, October 11.

Coleman, Rogers. 1990. Executive Vice-President, Blue Cross/Blue Shield of Texas, Dallas, Texas, Telephone interview, January 29.

Craig, Rebecca. 1988. "Making Ends Meet: Maximizing the Mental Health Dollar." National Conference of State Legislatures, vol. 13, no. 36 (November).

Dorwart, Robert, and Mark Schlesinger. 1988. "Privatization of Psychiatric Services." American Journal of Psychiatry, vol. 145 (May).

Health Insurance Association of America. July 1989. Research Bulletin: The Health Insurance Picture in 1988. By Jon Gabel, Steven DiCarlo, and Steven Fink. Washington, D.C.

Howard, Sheryl. 1990. Former Executive Director of the Texas Chapter of the American Psychiatric Association, Dallas, Texas. Telephone interview, January 26.

Howard, Lisa S. 1989. "Benefit Managers Eye Psych. Care Costs." National Underwriter (October 23).

La Sota, Jacqueline. 1988. "95% of Plans Provide Mental Health Benefits." Business Insurance (May 2).

Landes, Jennifer. 1990. "NY Targets Uninsured Children". National Underwriter (January 22).

Lewis, Janette. 1989. "Are Adolescents Being Hospitalized Unnecessarily?" Journal of Child and Adolescent Psychiatric Mental Health Nursing, vol. 2, no. 4.

Martin, Judy. 1989. Director, Communications and Information, Texas Medical Foundation Teleconference with data staff, December 19.

Priest, Susan. 1990. "Controlling Mental Health Costs: Full-Service UR Firms Offer Effective Benefit Management." Business Insurance (April 16).

Rodriguez, Alex. 1989. "Managed Care and Psychiatric Services." Yale Psychiatric Quarterly (January).

Rubin, Rita. 1989. "Mental Health Business Scrutinized for Ad Blitz." Dallas Morning News (September 5).

Saxe, Leonard, Theodore Cross, and Nancy Silverman. 1988. "Children's Mental Health: The Gap Between What We Know and What We Do." American Psychologist, vol. 43, no. 10 (October).

Sharfstein, Steven. 1985. "Financial Incentives for Alternatives to Hospital Care." Psychiatric Clinics of North America, vol. 83 (September).

____________. 1989. "Use and Funding of Services and Social Economics." Current Opinion in Psychiatry, vol. 2, pp. 688-690.

Sobehrad, Julie. 1989. Communications Division, Texas Medical Foundation, Austin Texas. Telephone interview, November 3.

Texas Department of Mental Health Mental Retardation (TDMHMR). September 1989. Future Direction for Comprehensive Community-Based Mental Health Services in Texas. Austin, Tex.

Texas Senate Interim Committee. 1989. Proceedings During the Meeting of the Ad-Hoc Committee on Psychiatric Hospitalization of Children, October 11, 1989, Austin Mental Health Association.

Texas State Board of Insurance. 1987. Report to the 70th Legislature from SCR 62 Advisory Committee on Third Party Payment of Costs for Mental Health and Mental Retardation Rehabilitative Services. Austin, Texas.

U.S. Congress, Office of Technology Assessment (OTA). 1989. Adolescent Health Insurance Status: Analysis of Trends in Coverage and Preliminary Estimates of the Effects of an Employer Mandate and Medicaid Expansion on the Uninsured. By Richard Kronick.

Chapter 11. The CASSP Model

The Child and Adolescent Service System Program (CASSP) is a federally funded program, first mandated in 1984, that supports states in their efforts to become more responsive to the mental health needs of children and adolescents. Working from the premise that present systems of care for severely emotionally disturbed (SED) youth are either nonexistent or woefully inadequate, CASSP actually seeks to "change the way services to this population are delivered by states and communities" (CASSP, May 1988, p. 1). The CASSP initiative promotes strategies for improving the system through more comprehensive and better coordinated services that are more readily available to SED youth. While the emphasis is clearly on a stronger mental health component within this system, the CASSP approach recognizes that this population has multiple needs, and therefore requires a multiple-agency approach that is strongly and efficiently integrated. Furthermore, CASSP advocates both for family participation in working with SED youth as well as for culturally sensitive service delivery to SED youth. Finally, largely through the efforts of a federally funded technical assistance center and two federally funded research and training centers, CASSP continues to provide technical assistance to states and to constantly evaluate the principles that define the program (CASSP, 1988, pp. 3-4).

The lack of attention to the mental health needs of children in Texas is an area of critical concern. While public support and the courts have forced a move toward the development of a community-based system of care for mentally ill adults, little such progress on behalf of children has been made. A CASSP grant was approved in the fall of 1988 for the Texas Department of Mental Health and Mental Retardation (TDMHMR). This state-level grant should assist the state of Texas in focusing on the needs of SED children and their families, in identifying the gaps in necessary services, and in facilitating a climate for change.

This chapter will focus on the CASSP program itself, the philosophies and goals which guide it, as well as the strategies and the system of care which it advocates. This chapter will also focus on the CASSP effort in Texas, as well as on certain programs already in place which incorporate the CASSP philosophy.

THE CASSP PROGRAM

Background

In 1982, Jane Knitzer's book, Unclaimed Children, indicted the mental health profession for its lack of attention to the needs of emotionally disturbed children. Knitzer claimed that two-thirds of all children with emotional problems do not receive needed services. She argued further that while many services are unavailable, too heavy a reliance on the more restrictive types of residential service has prevented more efficient, community-based services from developing (Knitzer, 1982, p. ix.). Federal funding had been largely responsible for this situation, with most funding going to medically oriented inpatient care rather than community-based outpatient care (Knitzer, 1982, p. x). The CASSP effort is the major federal policy response to this indictment.

Administered by the National Institute of Mental Health (NIMH), CASSP is a rather unique federal-state partnership that works to improve service delivery for its target population of severely emotionally disturbed children. Funds are granted to the state agency that has primary responsibility for providing mental health services for children. To receive this support, the applying agency must implement a "planning and strategy development process" which includes the following activities: (1) to establish a state-level administrative unit responsible for child and adolescent mental health programs, (2) to define the target population and the services necessary to meet the needs of that population, (3) to encourage cooperation with other agencies whose services impact emotionally disturbed children, (4) to design, both at state and local levels, strategies for improving the systems of care, (5) to provide technical assistance and training to those other agencies providing services, and (6) to establish demonstration projects which focus on particular innovative approaches that might be implemented statewide (Isaacs, September 1984, pp.16-17).

CASSP funding is rather limited; rather than providing any services, CASSP should be viewed as a "seed grant" initiative which encourages states to develop a full continuum of services (Inouye, 1988, p. 815). Three types of grants are available. A capacity-building grant initially helps states create a climate for systems change. When such a climate exists, a state-level grant is awarded to the child mental health authority to begin planning for the needs of SED children and their families. Private and public agencies are called upon at this time to build a coalition of support and services for emotionally disturbed children. Finally, local grants are awarded to build similar coalitions at the community level (CASSP, May 1988, p. 3).

Initial funding for CASSP was a $1.5 million grant to 10 states in 1984; by 1988, the appropriation was $7.4 million to 24 states (CASSP, 1988, p. 1). Current CASSP budget data on state grants show that 53 grants were awarded in 1989 (some states received more than one grant, and regional grants were made as well) for a total of $7 million. The total award to date is $26 million (Appendix 11.1). Federal funds also continue to provide research, training, and technical assistance through three centers: the Research and Training Center at Portland State University in Portland, Oregon; the Research and Training Center at the Florida Mental Health Institute in Tampa, Florida; and the CASSP Technical Assistance Center at the Georgetown University Child Development Center in Washington, D.C.. The Research and Training Centers are jointly funded for the 1989-1994 five-year period by the National Institute on Disability and Rehabilitation Research (NIDRR) and NIMH, while the CASSP Technical Assistance Center is funded jointly by the Office of Maternal and Child Health and NIMH for the 1989-1992 three-year period (Research and Training Center [Portland], 1989, p. 14). The Portland Research and Training Center in large part focuses on improved services to the families of SED youth. Currently, the Florida center is engaged in a longitudinal study of SED youth and continues to focus on alternatives to treatment as well as financing options. The CASSP Technical Assistance Center provides valuable technical and conceptual support to states; current projects include services for minority children and their families, the needs of high-risk children, and financing options (Research and Training Center [Portland], 1989, p. 14).

Because CASSP has been operational only since 1984, it is difficult to assess its impact. Certainly, it has provided tremendous technical support to states seeking to change their systems of care for children. Furthermore, it has provided a meaningful starting place for states that previously had no recognizable focus for SED children. In fact, Jane Knitzer argues that

> many of the states that now have CASSP grants [which] have publicly acknowledged a responsibility to domore for troubled children, are states that in 1982 had absolutely no commitment to improving children's mental health services. Moreover, the systems-of-care approach explicit in CASSP has given many of those seeking to improve children's mental health services a way of organizing steps toward change--something that has not happened before. (1988, p. 19)

The CASSP Strategy

As funding for CASSP is rather limited, the task of assisting states in their "pivotal" role of providing comprehensive and coordinated mental health services becomes particularly challenging. The complexity of the task requires careful stategies "that will have the broadest impact on the nature and organization of services for the target group with the limited Federal funds available" (Stroul, 1985, p. 3).

Recognizing that system change strategy is such a critical component of the CASSP effort, the CASSP Technical Assistance Center at Georgetown prepared Child and Adolescent Service System Program System Change Strategies: A Workbook for States in 1985. The state agency responsible for implementing the planning and development process for improving the system of care for SED children must engage in a clear process that will include administrative, legislative, and budgetary changes at the state level. Once such changes have occurred at the state level, similar activities must occur at the community level in order for the target population to be effectively served (Stroul, 1985, p. 3).

Strategies for Planning and Needs Assessment. In a typical CASSP-funded state, the state-level administrative unit is identified or established which specifically focuses on children's mental health needs and which serves as the "focal point" for CASSP-related activities. This unit then initiates a planning process which defines the target population, assesses their needs, defines the ideal system of care, and assesses available services as well as gaps. Through this planning process, which incorporates the input of "health and human service agencies, professional and provider organizations, parent and family groups, and advocacy groups," goals and priorities (all of which become the backbone of a comprehensive, statewide plan) are established (Stroul and Friedman, 1986, pp. 125-126). Planning and needs assessment are actually ongoing processes which require the formation of task forces and committees to not only achieve broad representation in the process, but also to assure the best possible system of care for the target population (Stroul, 1985, p. 40).

Strategies to Modify the Mental Health System. A number of other strategies are then employed by the state agency to implement the various CASSP objectives. Regulatory strategies are used to revise rules and guidelines for the system of care components. Similarly, legislative or budgetary strategies are employed to influence legislators on the program needs and funding requirements of the target population. The creation of new or alternative services is often necessary as a state seeks to offer a comprehensive and flexible system of care to emotionally disturbed children and families. The overriding goal in this strategy area is to "shift the philosophy, policies, practices and resources of the mental health system to promote community-based, child-centered systems of care" (Stroul and Friedman, July 1986, p. 125).

Strategies for Interagency Collaboration. Interagency collaboration is a critical strategic component which will be discussed in greater detail later in this chapter. Mental health services are closely integrated with the other agencies and services, such as education, child welfare, and juvenile justice, and others, because these services in many cases critically impact the target population. Strategies for achieving close collaboration include the creation of joint-agency task forces and study groups, as well as advocacy for the needs of SED youth within the different agencies (Stroul, 1985, p. 42).

Strategies for Technical Assistance and Training. Strategies for technical assistance and training in the CASSP approach are utilized at both the state and local level. A concerted effort is made to educate mental health staff, criminal justice personnel, government officials, educators, advocacy groups, parents, and others about CASSP goals and children's mental health needs. Surveys, workshops, seminars, or conferences are held to both educate about and advocate for necessary changes in how the needs of SED children can be met (Stroul, 1985, p. 44).

Strategies for Constituency Building. The value of a strong, committed, and vocal constituency is clear. Not only are key individuals and groups included in the planning process, but new advocacy groups are often formed to generate support and public awareness for the needs of the target population. The private sector is seen as an important partner in this process. States offer either material or nonmaterial support with the overall goal being to heighten public awareness and strengthen public support for the necessary changes in the system of care (Stroul, 1985, pp, 46-47).

Selecting the Strategy. The Workbook for States is an extremely complete document which includes innumerable choices the state agency may make as it sets out the course of systems change. Furthermore, the workbook provides resources that assist the agency in diagnosing its unique situation, in considering the strategy options, and in devising a plan of action that will best match their particular stage of CASSP-related initiatives. Such assessment is critical because federal CASSP funding is time-limited. In fact, it seems that "the overriding consideration in the strategy selection process should be how to use limited financial and other resources to achieve the most substantial and lasting changes in relation to system of care development for severely emotionally disturbed children and youth" (Stroul, 1985, p. 61).

The CASSP Philosophy

As the CASSP effort has grown, the philosophy behind it has evolved. The initial motivation to deliver services to disturbed children in a more responsive and efficient manner has developed into a philosophical framework which incorporates all aspects of an ideal mental health system. This framework is based on the premise that children with emotional problems have a multiplicity of needs and is guided by two central values: (1) the program is child-centered, with the needs of the child and family dictating the services provided, and (2) the system is community-based, providing less restrictive, more normal settings for children and their families whenever possible, and as close to their homes as possible. By placing the child and his or her needs at the very center of the service framework, CASSP in a sense revolutionizes children's mental health services.

Many of the ideas set forth in Knitzer's Unclaimed Children have been incorporated into the CASSP philosophy. Highlighting innovative programs that are more responsive to the needs of SED children and their families, Knitzer advocates an approach that goes beyond the traditional therapist's office and instead provides "case advocacy" for children and families caught between numerous systems of care (Knitzer, 1982, p. 17). Most experts agree that the needs of severely emotionally disturbed youngsters cannot be met by a mental health agency operating in isolation, yet interagency cooperation alone is not sufficient. A comprehensive and coordinated system of care must be in place. Beth Stoul and Robert Friedman, in A System of Care for Emotionally Disturbed Children and Youth (1986), define this more integrated system of care as "a comprehensive spectrum of mental health and other necessary services which are organized into a coordinated network to meet the multiple and changing needs of severely emotionally disturbed children and adolescents" (1986, p. iv).

Stroul and Friedman state that this system goes beyond what is generally considered a "continuum of care" for SED children and youth because it not only connotes the range of mental health services (from restrictive to nonrestrictive) but also incorporates the other services and mechanisms necessary to truly treat the whole child. Furthermore, parents, viewed in most cases as the primary caregivers, should be supported and involved as much as possible. The CASSP philosophy states a clear commitment to preserving the integrity of the family whenever possible.

THE SYSTEM OF CARE

The Framework

The basic rationale behind this system of care is that it provide a wide range of services in a highly flexible manner, always recognizing the individual differences of children and their families. The system must meet the child's needs and not attempt to make the child's needs fit the system (Friedman, 1988, pp. 3-4). The system of care set forth by Stroul and Friedman is function-specific rather than agency-specific. There are seven essential components of service (Mental Health, Social, Educational, Health, Vocational, Recreational, and Operational) which are grouped together with the child at the center of the model (Appendix 11.2). Each component of care is further defined by the types of service that the particular dimension is able to provide the child in need (Appendix 11.3). These components, when acting together, "wrap" services around the child. Rather than specify which agency should provide which service, the various components work to ensure that the multiple needs of the disturbed child will be met in a coordinated manner.

The Emphasis on Mental Health

The Mental Health Component. Stroul and Friedman emphasized that while each dimension is a critical component of the system, it is necessary to focus on the mental health continuum, because services for SED children are particularly lacking in this area. With the overriding goal being to treat the child in the least restrictive setting possible, "the system capacity in the more intensive of the non-residential services should exceed the system capacity in the residential service components" (Stroul and Friedman, 1986, p. 29). Furthermore, it is stressed throughout the literature that less restrictive need not imply less intensive (Friedman, 1988, p. 4).

In the CASSP model, the mental health service continuum consists of seven nonresidential categories and seven residential categories (Appendix 11.4). The nonresidential component includes prevention; early identification; assessment; outpatient treatment; home-based services; day treatment; and emergency care. The residential component (which has traditionally meant inpatient care in psychiatric hospitals) is now emerging as a continuum of services also and includes therapeutic foster care; therapeutic group care; therapeutic camp services; independent living services; residential treatment; residential crisis services; as well as inpatient hospitalization. While the residential options are presented in increasing order of restrictiveness, it should be noted that restrictiveness is not necessarily determined by the severity of the problems of the youngsters served by the various alternatives. It is not merely important to determine which programs can serve the more difficult youngster, but rather which program can best be matched to the particular needs and assets of the individual child. While CASSP theory stresses that all treatments are critical components of the comprehensive system, in many cases, programs offer overlapping services and differences are particularly difficult to distinguish. While it is beyond the scope of this chapter to define each category of the mental health continuum in complete detail (the reader is referred to Stroul and Friedman's System of Care), it is important to emphasize that each component strive toward the ideal of accessible, timely, and intensive treatment that works at keeping the child in as normal a situation as possible.

This chapter will focus on those services most consistent with the CASSP goal of the least restrictive, most normative setting. Certain treatments within this continuum have merited increasing attention as they are being viewed as therapeutically more effective, less costly, and more appropriate for children and adolescents. Intensive home-based services, day treatment, and flexible crisis-oriented outpatient therapy, all innovative alternatives to inpatient hospitalization, have proven particularly effective (Research and

Training Center for Children's Mental Health [Tampa], 1989, p. 8). Therapeutic foster care, a residential option, is also emerging as a less costly but highly effective treatment option for SED children. Prior to CASSP, funding for such programs was so low that very few states were servicing children in these ways, and major gaps therefore existed in the mental health service delivery for children. Implementation of such programs is definitely growing, but not at a rapid enough pace to meet the demands of SED children and families.

Home-based Services. While not a new concept for health and education, home-based service is a relatively new trend in mental health and refers to interventions delivered to children and families in the home. While removal from the home had generally been considered protection for the child (and in some cases the family), such thinking fostered the myth that treatment must occur in a hospital or other residential setting. Funds have traditionally usurped the family role rather than empower the family, and substitute care has too often been used as a first response rather than a last resort (Stroul, October 1988, p. 12). Numerous problems exist with such an approach, not the least of which are the high cost of substitute care and the social and psychological risks for SED children. Another critical consideration is that the changes which occur during intensive treatment outside of the home often do not carry over when the child is placed back in the home (Stroul, October 1988, p. 13).

Home-based service is "based on the philosophy that family is the most powerful social institution and that families should be supported and maintained whenever possible" (Stroul, October 1988, p. 14). Hence, family empowerment is a major goal of any home-based treatment. Rather than projecting any blame on the family for the child's problems, services instead "support , encourage, and assist them in their.parenting.role " (Stroul, October 1988, p. 14).

Home-based services are also viewed as ecological. The many outside factors that might influence a child, such as school or peers, are considered in this treatment. While there is considerable debate as to how long and how intense home treatment should be, it is important to note that the linkages within the community that home-based service provides make it a particularly attractive treatment concept (Stroul, October 1988, pp. 22-23). Furthermore, intensive home-based interventions have successfully served many youngsters with very serious problems for whom residential care was thought to be needed (Stroul and Friedman, 1986, p. 47).

Numerous short-term, home-based programs are modeled after Homebuilders, a pioneer program begun in 1974 in Tacoma, Washington. Family preservation is the central goal of the Homebuilders program, which stresses that "children have a right to benefit from the special and enduring family ties that are present in even the most seriously disturbed families" (Stroul, October 1988, p. 85). Proponents of this short-term model claim that families are most motivated to change during periods of crisis. Four to six weeks of intensive intervention aim to stabilize the family and to avoid the risk of out-of-home placements Extremely small case loads permit workers to provide highly intensive services, sometimes as many as 10 to 20 hours per week. The program emphasizes three interventions: counseling, skill building, and coordination with other community services (Stroul, 1988, p. 88). Homebuilders is designed to help only the most seriously disturbed families, and success rate is "defined as the percentage of potential removals who remain out of state-funded foster care, group care, or psychiatric placements. The overall success rate has been high, and at 12 months after the first intervention it is reported at 88 percent" (Stroul, October 1988, pp. 92-97).

The Satellite Family Outreach Program is another successful home-based program. Satellite serves an inner-city population in Chicago with a long-term, sometimes less-intensive intervention than Homebuilders. Equally committed to the primacy of family and the goal of family preservation, Satellite offers a wide range of services: crisis intervention, counseling, homemaker services, financial planning, on-call nursing, sex and drug education, nutritional consultation, as well as collateral services with other agencies. Unlike Homebuilders, Satellite is not time-limited. However, viewed as an alternative to residential treatment, it becomes a cost-effective service (Hardy, 1986, pp. 1-6).

The reported costs for home-based services vary widely. Some programs report costs per episode, others per year, and others per family. Research in 1982 suggested a range from $1,000 to $10,829 per family; research in 1986 computed the cost at $3,000 to $5,000 per episode. Of the two programs described in this chapter, Homebuilders (the short-term program) reports funding as $2,600 per family, and Satellite (long-term) estimates costs for a family at $21,600 over an 18-month period (Stroul, October 1988, pp. 45-47, 116). The important issues seem to be that the reported costs are those required to serve an entire family (rather than to serve one child in an out-of-home placement), and that cost of an average episode of in-home service is always far less than the average cost of an out-of-home placement (Stroul, October 1988, p. 45).

Evaluation of home-based services is particularly challenging and usually centers around two central issues: (1) whether an out-of-home placement was avoided and (2) whether families remained intact. Some programs discuss reunification success, while others (such as Homebuilders) try to assess improvements in overall family functioning. Some research indicates that duration of services as well as completeness of services may be two appropriate indicators of success. Overall, while more research is clearly necessary, most researchers conclude that home-based services provide an important strategy for treating children with emotional problems, as well as their families, and that greater availability of such services will allow more troubled children to remain at home, while those who truly need residential treatment will get it (Stroul, October 1988, pp. 48-54).

Day Treatment. In An Introduction to Day Treatment for Emotionally Disturbed Children and Adolescents, Robert Friedman argues that day treatment is an often neglected but particularly effective treatment approach for SED children and their families. Day treatment employs a "coordinated and intensive set of educational, therapeutic, and family services" and should be viewed as a valuable component of a community-based program (1980, p. 1).

Friedman outlines the critical features of a day treatment program as follows:

1. All services within a day treatment program are be coordinated by the same agency to simplify treatment and staffings.

2. Treatment of the child occurs on an intensive basis, for at least five hours daily, Monday through Friday, with family contacts on a weekly basis.

3. A combination of educational, therapeutic, and family services is offered. Services are based on careful assessment and are individualized.

4. A multidisciplinary team of educators, psychologists, social workers, counselors, psychiatrists, and other professionals plan the treatment. (1980, p. 2)

Day treatment is considered the most intensive set of services offered on a nonresidential basis, and has been used successfully, not only for children at-risk of out-of-home placement but also for children experiencing transition from a residential setting back to a family setting (Friedman, 1980, pp. 3-4). Some new day treatment programs are emerging for older and more difficult to treat adolescents, but progress in day treatment programs seems to be particularly slow. Turf issues between education and mental health are often the most difficult to overcome (Knitzer, 1988, p. 20).

A CASSP profile of day treatment programs for SED youth, prepared in 1985 by Mareasa Isaacs, Ph. D., and Sybil Goldman, M.S.W., describes three successful day treatment programs: ADVANCES in Reading, Pennsylvania; City Lights, in Washington, D.C.; and Poyama Land, in Independence, Oregon. While these programs differ in certain respects, the authors maintained that a surprising consistency of philosophy and practice exists. The majority of the children served in these programs come from low-income, often fragmented families. The majority are diagnosed as having conduct disorders, attention-deficit disorders, affective disorders, or adjustment disorders. All programs stress the value of a safe and nurturing environment, and are committed to a client-centered, highly individualized approach that tailors treatment to the needs of the child. While treatment strategies vary, family involvement and group activities are essential. Furthermore, the educational component is closely interfaced with the therapy component, ensuring a continuity of treatment. Staff is a vital element of a successful day treatment program. Successful programs boast dedicated and committed staff, and the staff/client ratio is high (Isaacs and Goldman, September 1985, pp. 27-36).

Day treatment costs for the programs mentioned above ranged from $7,600 to $25,092 per year. Stroul and Friedman (1986, p. 45) reported day treatment costs at $10,000 to $15,000 per child. Differences in cost may be accounted for by structural differences in programs as well as geographical cost of living expenses. Most programs are largely dependent on public funding (by as much as 90 percent), and in many cases, waiting lists suggest the need for expanded or additional programs of this type (Isaacs and Goldman, September 1985, pp. 37-38).

The effectiveness of a day treatment program can be assessed in a variety of ways. Poyama Land and ADVANCES both examined whether clients were successfully assimilated into the school and community upon discharge, as well as how involved the whole family was in the treatment process. ADVANCES investigated other factors after discharge such as client satisfaction, employment, drug use, and convictions (Isaacs and Goldman, September 1985, p. 61). Regardless of the theoretical orientation of programs, most research seems to indicate that day treatment programs provide a successful treatment option that allows disturbed youngsters to remain with their families, thereby eliminating the need for much more costly residential treatment.

Crisis Services. Crisis services are also referred to as emergency services, crisis intervention, or crisis stabilization. Whatever the name, the goal is the same--to provide immediate assistance to an individual or family in acute crisis. The crises may vary, and the providers may change with the circumstances; but while the need is great for such services within the continua of mental health services, not many such services exist (Goldman, 1988, p. 12).

The underlying goal of all crisis programs is to avert hospitalization. Considering this goal, crisis intervention on an outpatient basis is a particularly effective mental health approach. Hospitalization is often viewed as a disruption in a child's life, and treatment which instead utilizes the "natural networks" and equips the youngster and family with coping skills for the future is definitely preferable. Like the two previously discussed treatments, crisis intervention is "grounded in family systems theory" and therefore approaches the whole family, not the individual, as client (Goldman, 1988, p. 14).

Crisis intervention programs operate under the assumption that a person's functioning is impaired by some environmental factor and that he or she lacks the coping skills to adapt. Such programs intervene immediately, engage in brief and intensive problem solving, involve all family members, and link with other community support systems.

Community-based crisis intervention programs generally include crisis-telephone services or hotlines, walk-in intervention, mobile outreach, and crisis residential services or shelters (Goldman, 1988, p. 22). Of all the treatment approaches included in the community-based system of care, crisis services seem the most difficult to categorize. Often associated with a larger service network, such as a guidance center or hospital setting, crisis services become part of a range of services and are often backed up by additional services. For example, services affiliated with a hospital setting might offer inpatient care if necessary, while those affiliated with a guidance center might provide more in the context of diagnosis and assessment.

Emergency shelters which provide walk-in crisis intervention generally provide the briefest intervention. Emphasis at such facilities is usually on problem resolution and planning, and often an attempt is made to reestablish contact between family members. Huckleberry House, an emergency shelter in Columbus, Ohio, reported that the cost of counseling and shelter over a four-day period (the average length of stay) is $581 per youth (Goldman, 1988, p. 44).

Crisis intervention services provided in a hospital or other residential setting are usually for longer duration and include a wider range of treatments. One excellent example of a crisis-intervention program which offers a wide range of services is the Children's Crisis Intervention Service (CCIS), part of the Transitional Residence Independence Service in Camden, New Jersey. CCIS provides services that are short-term and intense, and aimed at crisis stabilization. The maximum stay at the 12-bed facility is for 28 days, as mandated by the state. Services at the facility include clinical supervision, psychiatric evaluation and treatment, 24-hour nursing coverage, therapy, and recreational and educational activities. In addition, community linkages, provided through excellent case management services, are an important goal of the program. Obviously, the cost for such services is high compared with other interventions provided in a nonresidential setting--the cost per child is estimated at $7,668. However, it is often this short-term, intense approach which becomes an effective tool for avoiding a longer-term hospital placement; even this cost is low when compared with the costs of long-term inpatient care. Waiting lists for CCIS are long, and outreach services have been developed to help stabilize that population who cannot be admitted immediately (Goldman, 1988, pp. 72-78).

Evaluative data for crisis services, as for other community-based services, are not readily available. There is no single qualitative or quantitative factor on which to measure success, although most programs seem to use the prevention of hospitalization or other more restrictive setting as an indicator. Other measures considered are readmission rates and the overall improvement in the child's or family's functioning. Furthermore, individual crisis programs vary so much that it is difficult to compare them. However, certain benefits do seem apparent. Community-based crisis-services often become an "effective gate keeper" to hospitalization; often provide a cost-effective alternative to hospitalization; frequently enable children to remain in communities; link families with community support systems; and provide a timely response that often prevents the escalation of a crisis (Goldman, 1988, pp. 44-48). In addition to such positive successes, problems are also evident. Funding, recruiting staff, staff burnout, inadequate follow-up, lack of coordination between services, as well as the rise in the numbers of psychiatric hospitals, are all cited as challenges to successful program implementation (Goldman, 1988, pp. 49-50).

Therapeutic Foster Homes While judged to be the least restrictive of the residential alternatives, therapeutic foster care is certainly not the least intensive service. Therapeutic foster care may be used to treat children with severe problems as well as the more restrictive (and more costly) residential options such as residential treatment centers or inpatient hospitals (Friedman, 1988, p. 5).

Therapeutic foster care is an attractive treatment option for several reasons. The homes are flexible and relatively easy and inexpensive to start up. Foster parents are recruited and specially trained to work with emotionally disturbed children. Usually only one child is assigned per home. Staff-to-client ratio is high, allowing staff to work closely with not only the child but also with the foster and biological parents. No special physical facility is required, and cost-sharing for specialized services keeps the costs of the program low. While precise costs of such programs are difficult to estimate, mainly because of the differences in stipends that programs pay foster parents, the range of $10,000 to $20,000 per child per year is estimated (Stroul and Friedman, 1986, pp. 47-49).

PRYDE, a "foster family-based treatment" in Pittsburg is a successful foster care model that provides parents with intensive training in behavioral techniques which they then use with children in the home setting. Research from the PRYDE program is encouraging: not only is there a high success rate at discharge, but also 83 percent of the children are doing well in less restrictive settings two years later. Monthly stipends for these programs generally run about $600 above normal foster rates (Stroul and Friedman, 1986, pp. 48-50). Therapeutic foster home programs in Florida, which demonstrate considerable success, provide parents with a more modest stipend--approximately $150 above normal monthly foster rates--to parents as well as a less technical training, and depend largely on the environment of the therapeutic home to treat the child (Stroul and Friedman, 1986, p. 47).

Research as to the efficacy of this type of service is still limited. One critical finding that has emerged is that the quality of posttreatment available may perhaps be the single most important factor in predicting success. Residential treatment is only one step in an ongoing process that begins before placement and continues after discharge, and it is critical that the family environment be strengthened throughout this process. Robert Friedman argues that "the family should be involved throughout the entire time the child is in treatment, regardless of the setting" (1988, pp. 10-11). Furthermore, therapeutic foster care is no more likely to be successful than home-based or day treatment programs. In fact, because these treatments can all be demonstrated to be similarly effective, the burden becomes to demonstrate a clear need for these children to be out of their home, as well as to show that the opportunity was provided to serve these youngsters in a more intensive, nonresidential setting before removal. If such services were clearly not available, then from a clinical standpoint, placement in a foster home could be much more easily justified (Friedman, 1988, pp. 7-8).

Operational Services

These services are the components of the system of care which may make a difference between the system working or not. Rather than being part of any one category of services, they cross the barriers of all and are necessary aspects of each. Operational services, particularly case management, advocacy, and support groups, merit increasing attention by CASSP in its research and technical assistance efforts, and each has been found to be critical in the success of mental health services to children.

Case Management. Case management has been called "perhaps the most essential unifying factor in service delivery" (Stroul and Friedman, 1986, p. 93). Case management, the actual "wrapping around of services" referred to by so many professionals in the field, is the necessary outreach to the child and family, placing them in touch with all the available services and agencies so that treatment will be effective. Case management basically makes the system work.

The Willie M. Program in North Carolina provides one of the most successful models for a case management approach for treating SED children. The Willie M. Program strives for small case loads--generally 12 to 15 cases per worker--in the belief that small case loads guarantee a higher success rate which in the long run is more cost effective. On the other hand, public agencies often seek case loads of 30 in an effort to serve more children. The North Carolina program advises a flexible funding system so that workers may purchase whatever treatments seem most warranted for each case. Case management is generally provided only to those youngsters in most serious need. In North Carolina, where the Willie M. Program grew out of court mandate, all youngsters who meet the criteria are served. In another case management program in Florida, those SED children who meet the criteria for residential placement become candidates for case management services (Stroul and Friedman, 1986, pp. 95-96).

While case management in some cases is viewed in the clinical sense, the multiple requirements of SED youth usually demand more extensive case management treatment than the direct clinician might provide. Stroul and Friedman (1986, pp. 93-95) maintained that case managers who are not the primary treatment agent may be able to more effectively advocate for their clients. Furthermore, case managers may be more effective when placed in a position that "accords them both considerable independence and influence within the overall system." CCIS, discussed earlier in the crisis intervention section, provides a continuum of care, in which case management plays a vital role. Case management is the outer layer of the CCIS model. The model then encompasses numerous other treatments for the family and child, who are envisioned at the center. The primary role of the case manager at CCIS is to "work closely with other community agencies for information gathering, treatment, planning and referrals" as well as to ensure close follow-up on a client discharged from the center (Goldman, 1988, p. 82).

In spite of the critical aspect of case management, this component is a particularly difficult one to classify. Should case management be a function of clinical treatment, or should case management operate independently with influence and control over the whole system? How large a case load can a case manager effectively handle, and how should case management be funded? How effective is case management? Unfortunately, the scarcity of programs in place and the lack of careful research on this critical operational service make it a particularly difficult component to evaluate.

Support Groups/Advocacy. Support groups for parents of SED youngsters have been scarce commodities in the past, but efforts in this direction have improved drastically in recent years. It seems that many parents of children with emotional problems have been

> silent and isolated because of stigma, blame by professional helpers, feelings of hopelessness, guilt, and the daily demands of living with a child who has emotional problems. Many parents have felt professionals, agencies and society blame them for their child's problems. (Donner and Fine, 1987, p. 3)

Parental involvement is increasingly seen as a vital direction by CASSP. The parent is frequently the one consistent caregiver and can be particularly helpful in planning for the child (Research and Training Center for Children's Mental Health [Tampa], 1989, p. 6).

Parents of children with serious emotional problems are encouraged to develop a self-help/advocacy group. Such groups not only provide a supportive atmosphere in which to share experiences and coping strategies; even more so, they become effective forums for advocacy within the community. Through such groups, parents develop collaborative relationships with professionals, educate the public on the needs and problems of SED children, and work as "allies" with professionals to effect changes. Professionals involved in such groups also receive valuable feedback on the services the seek to provide, as well as benefit from the collaborative relationship with parents which is so necessary to changing systems (Donner and Fine, 1987, p. 5). The Georgetown University Child Development Center has provided a workbook for parents seeking to establish support groups. The workbook is a valuable resource that addresses the necessary steps in meeting with key mental health leaders, assessing strengths and problems of the service system, and accessing other parents who might be interested in participating.

Jane Knitzer, in discussing the growth of a "new advocacy momentum" for disturbed children, said that the value of parent advocacy groups cannot be underestimated and may be the single most important factor in reform. In addition, class advocacy efforts, at both the national and state level, have definitely given these children a "new visibility" on their agendas (Knitzer, 1988, p. 21). It seems that advocacy efforts have been helpful in setting the stage for change:

> A workable policy context, emphasizing state leadership, interagency planning and a systems-of-care perspective is in place. . . The tragic irony is that the larger economic and political context is not hospitable to these kind of changes. Even as it becomes clearer and clearer that strategies for helping troubled children . . . are becoming more effective, the erosion of dollars to set up or continue programs using these strategies, coupled with the absence of clear federal and state mandates to serve these children, . . . threatens to undo the gains of the past few years . . . Now, more than ever, strong advocacy on behalf of troubled children and adolescents is critical. (Knitzer, 1988, p. 25).

Balancing Service Capacity

Issues and Trends. In an article discussing the availability of mental health services for children, June Tuma says that while "the magnitude of children's mental health problems is clear,. . . it is difficult to specify what types of mental health services are needed and how many are available (1989, p. 190). The statistics regarding the number of children in need of services can vary anywhere from 10 percent to 15 percent. In 1988, Leonard Saxe et al. reported that of the 11 percent of the nation's children in need of treatment, less than half were being served (p. 800). In 1989, Tuma reported that approximately 70 to 80 percent of those children with emotional problems were not receiving appropriate services (p. 190). Although mental health authorities agree that the most desirable treatment is that delivered in the least restrictive setting, how to achieve the proper balance among all levels of care is a major challenge.

In 1988, NIMH published a report of the Invisible Children's Project which focused on the number of SED children being served in either out-of-state residential treatment centers, state mental hospitals, or in-state residential treatment facilities. The report argued that often "state agencies did not know the exact number of children they placed in out-of-state and in-state residential treatment facilities, the amount of money being spent on their treatment, their diagnoses, and even their whereabouts" (Research and Training Center for Children's Mental Health [Tampa], 1989, p .1). However, the data from 37 states did show that 4,926 children and adolescents were placed in out-of-state facilities, and nationwide data showed 22,578 children had been treated in state hospitals in a one-year period. Although residential treatment is sometimes necessary, as the report allowed, it seems apparent that many of these children could have been helped in their own community had services been available (Research and Training Center for Children's Mental Health [Tampa], 1989, pp. 1-16).

Conflicting trends seem to be occurring. Saxe et al. discussed the trend toward increased "privatization of care and a general increase in the use of psychiatric hospitalization" (1988, p. 802), while Tuma noted that there has been a gradual shift toward nonresidential community-based settings (1989, p. 190). Indeed, Robert Friedman, in a paper on major issues in children's mental health, maintained that within the public sector there is clearly a move away from the more costly hospital and residential treatments, while at the same time "there has been enormous growth in private placements of adolescents in psychiatric hospitals" (1986, p. 4). Friedman further defined the problem for policymakers particularly. Because services for emotionally disturbed youth are expensive and can be long-term, they may "drain resources from the prevention, early identification, and early intervention efforts that may have the greatest impact in the long run" (1986, p. 4). Such arguments certainly point toward the use of less costly but effective treatments.

Possible Solutions. In comparing the effectiveness of different treatment settings, the research base is relatively weak. Friedman, in an report entitled Service Capacity in a Balanced System of Services for SED Children, provided a possible model based on the best available data to help policymakers proceed with systems development. In preparing the model, certain assumptions were made. The prevalence of emotional disturbance was assumed to be in the 2 to 5 percent range, with the public sector serving approximately half of these children. Residential services were assumed to be necessary for only 1 percent of this population. For purposes of planning, residential services were divided into three groups: medium to long-term care settings such as hospitals and residential treatment centers (RTCs); short-term hospitals or nonhospital crisis stabilization units; and medium to long-term residential care in a less restricted setting, such as therapeutic foster homes (TFC), therapeutic group homes (TGH), and wilderness camps. Additionally, nonresidential services were similarly divided into three categories: home-based; day treatment; and outpatient. Case management and parent support were assumed to be separate services, and it was estimated that many youngsters would require more than one mental health service during treatment. The number of youngsters served would depend not only on the capacity of any one service, but also on the turnover rate. The model presented is based on a population of 10,000 children and borrows extensively from the North Carolina project (Friedman, 1987, pp. 1-3).

Based on the above assumptions, proposed capacity for a balanced community-based system of services per 1,000,000 youth is as follows. In a residential setting, 100 children would receive long-term treatment in a hospital or RTC, 100 would receive short-term treatment in a hospital or crisis-stabilization unit, and 800 would be placed in a less restrictive setting, such as a TFC or TGH. Of those served in a nonresidential setting, 2,000 would use home-based treatment, 2,000 would use day treatment, and 8,000 would receive outpatient care. Case management would be provided for 4,000 children and parent support for 2,400 or 20 percent of the youngsters served. Total capacity would be 17,000 youngsters served (with 5,000 receiving multiple services) for a total of 12,000 youths served. The capacities presented in Friedman's model are based on a six-month turnover rate of 2.4 percent of the youth (or 24,000) and a nine-month turnover rate of 1.8 percent of the youth (or 18,000) (Friedman, 1987, p. 4). In using this model to plan for a balanced system of services, communities would indicate their present service capacity in relation to the figures presented. Costs for the system would be computed by identifying the unit costs for each service and then multiplying the costs by the number of units to be provided per year (Appendix 11.5).

The model, as presented, is clearly weighted in favor of the community-based, nonresidential treatments. Residential treatment options are heavily weighted in favor of TFC. Friedman explained that this model is focused on services specifically for SED children and that it does not include interventions in prevention or early identification. These additional services are critical ingredients of any program that aims to reduce emotional disturbance and must be considered as well in an overall plan. Additionally, Friedman admitted the need for advocacy, interagency collaboration, family-focused nonrestrictive services, as well as accurate gate-keeping and tracking mechanisms for children served by the system (1987, p. 4). The Invisible Children's Project, described above, argued for much the same focus and called on states to develop specific plans to bring children home from state hospitals as these plans are implemented (Research and Training Center for Children's Mental Health [Tampa], 1989, p. 16).

In considering the service capacity of any model, it seems important to note that the community-based services which have been targeted as cost-effective alternatives to residential treatment share many features. Home-based services, like therapeutic foster homes, provide "intensive work with each child and family, individualized programming for the youngsters, training and other support for the parents, small caseloads for the program staff, and a capacity to make an immediate response in times of crisis" (Friedman, 1988, p. 13). Home-based services and crisis services both work to strengthen the family, work through crises, and provide community linkages. Day treatment, like therapeutic foster care, seeks to maintain the child in a community setting. Given these and other commonalties, some agencies have worked at providing several service options together and might use a less intense or nonresidential service, such as home-based care, as the gate-keeping mechanism for another service such as therapeutic foster care. This diversification and blending of services would be an effective way of assuring that all of the various options are available and accessible at the time a child needs them.

INTERAGENCY COORDINATION

Fragmentation of Services

Although there is general agreement about the need for a balanced, community-based system of care, certain impediments to progress exist. The lack of coordination among agencies that provide services to children is one of the critical factors affecting the development of effective services (Saxe et al., 1988, p. 800). CASSP is in large part the response to this fragmentation of services (Dougherty, 1988, p. 810). Because other systems of care such as education, health care, child welfare, and juvenile justice are so clearly involved in both the prevention and treatment of children's mental health problems, and because children's mental health problems often involve complex "environmental risks such as poverty, inadequate care, parental alcoholism, school problems, and so on, to deal effectively with these problems, coordination of all the services that make up a child's environment is absolutely necessary" (Inoyue, 1988, p. 814).

Children's mental health services are offered in a wide range of other settings. Therapy of some kind might occur in schools, health clinics, child welfare agencies, or in the courts. Where such therapy occurs can often determine both the effect and cost of treatment (Saxe et al., 1988, p. 802). In fact, these other systems, which are so "naturally involved in the lives of most children," are often the first to identify problems. Furthermore, treatment within these more natural settings could be more effective (Tuma, 1989, p. 194). The overriding problem seems to be one of collaboration. Even after an agency refers a child for services, poor follow-up or a lack of coordination often results in a child missing out on the services he or she needs.

Other Settings

Juvenile Justice. In 1985, CASSP cosponsored a symposium to address the mental health needs of the juvenile justice population. The symposium recognized the clear need for improved interface between the two systems and advised that mental health should have prime responsibility for direct service intervention of mental health problems for this population, as well as provide necessary diagnostic and consulting services. While the symposium maintained that only 1 to 2 percent of the juvenile justice population is clearly mentally disordered, presenters did agree that mental health services should be provided even to those not specifically diagnosed as mentally ill. The symposium recognized that services to emotionally disturbed/mentally ill youth of the juvenile justice system are the joint responsibility of the state mental health and juvenile justice system, and recommended that all relevant service providers and advocacy groups link together for needs assessment, program coordination, technical assistance, and research (Isaacs, November 1985, pp. 33-36). Three years later (November 1988), in a survey conducted by

State Mental Health Representatives for Children and Youth (SMHRCY), improved collaboration with the juvenile justice system was still identified as one of the top ten priority issues for children's mental health (Research and Training Center for Chidren's Mental Health [Tampa], 1989, p. 3). It seems that such collaboration, while clearly necessary, is difficult to achieve.

Educational Services. The Education for All Handicapped Children Act of 1975 (PL 94-142) provided a legislative mandate for school-based identification of mental health problems and required that children with emotional disturbance receive the services necessary to allow them to learn. The law has been a motivating factor for collaboration between mental health and other service providers, although there has been confusion over who pays and for which treatments (Saxe et al., 1988, p. 802).

It does seem that the school system, the largest single agency that affects the nation's children, has the greatest potential for identification and treatment of children with problems. Yet in spite of a heavy reliance on special education and other school-provided services (counselors, school psychologists, and social workers), mental health practioners are finding that "overall, mental health interventions within the schools are not wide-spread, nor are they coordinated with other systems of care" (Tuma, 1989, p. 195). The SMHRCY identified collaboration with special education as number three of the top ten issues facing mental health (Research and Training Center for Children's Mental Health [Tampa], 1989, p. 3).

Child Welfare. Although child welfare provides numerous therapeutic services for abused, neglected, and troubled children and their families, generally coordination between child welfare and mental health service systems is poor. Evidence suggests that "the profiles of children and adolescents coming before the child welfare and mental health systems are increasingly similar, with both systems reporting more serious behavioral and emotional problems and more widespread patterns of violence and dysfunction among the families" (Knitzer, 1989, p. 2). These children are often the very same children (referred to as "mad, bad, sad, and can't add"), and as "cross-system veterans" for whom all the services must mesh, they present a clear challenge to the system (Knitzer, 1989, p. 2).

Foster care is one of the major welfare interventions for at-risk children. Although permanency planning has become a major goal of states, long-term foster care is a problem. Approximately 66 percent of those entering foster care as children, and approximately 88 percent of those entering foster care as adolescents, are still in foster care at 18 years of age. While such long-term foster placement carries a wide range of risks, studies show that 85 percent of those displaying psychological problems at entry received inadequate mental health services during foster care (Tuma, 1989, p. 195). Therapeutic foster care, day treatment, and respite care for the family or foster parents are critical mental health services and should be better coordinated for the population served by child welfare. The development of "better multi-system programs between mental health and child welfare" was considered the top priority of the 1988 SMHRCY survey (Research and Training Center for Children's Mental Health [Tampa], 1989, p. 3).

The most striking call for collaboration between child welfare and mental health services comes from Jane Knitzer and Elizabeth Cole in their analysis of family preservation services. With family preservation viewed as a desirable alternative to placement, and with intensive home-based services viewed as the most appropriate treatment to achieve that goal, the opportunity for collaboration between services is enhanced. The authors discuss such tactics as joint referral, multiagency advisors, joint funding, and multiagency planning, and argue that these approaches will not only improve the chance of family preservation but will also reduce fragmentation of services (Knitzer and Cole, 1989, pp. 4-27).

Health Care. As physicians are often the first professionals to treat young children, they often have the opportunity to consult and advise parents as to the mental health problems of their young children. These professionals, while often supportive in this role, are not often well informed about mental health issues and are often not trained in diagnosis and early identification of problems. Because the opportunities for collaboration are obvious, particularly in the area of early identification, there remains a critical need for better informed pediatric mental health specialists as well as better coordination between the two service systems.

State Coordination

Background. In the effort to improve service to multiproblem children, states use three methods to coordinate services and strengthen interagency cooperation: (1) a consolidated youth agency; (2) a "quasi" consolidated youth agency; or (3) a formal coordinating mechanism for youth services. In a 1984 report prepared by Mareasa Isaacs, 15 states that use one of these three approaches were selected to describe them. In all cases, the coordination was a result of "legislative or executive mandates, or of strong child advocacy efforts in the state" (p. 1). In each case the intent was the same--to pick up children who otherwise might fall through the cracks of a poorly coordinated system.

Single Consolidated Agency. In states with a single consolidated agency, the new agency assumes responsibility for those youth services, such as welfare, juvenile justice, and mental health, administers the programs, and directs the traditional management functions, such as planning, budgeting, and data collection. Connecticut, Delaware, and Rhode Island use this type of plan. It is a particularly difficult plan to develop because it arouses considerable concern about agency autonomy and position (Isaacs, September 1984, p. 6). However, such a program does increase visibility for children's services in general and may effectively coordinate both management and advocacy. There may be a real risk of the mental health component losing out in either competition for funds or emphasis (Isaacs, September 1984, pp. 2-7).

"Quasi" Consolidated Agencies. States with quasi-consolidated agencies are similar to those states with a single consolidated agency, but the quasi-consolidated agency is usually developed as "divisions within existing umbrella agencies" (Isaacs, September 1984, p. 7). In Florida and New Hampshire, where this method has been attempted, the mental health department maintains some autonomy, but there is still the concern of duplication of services, as well as concern that the welfare philosophy may dominate. Encouragement of joint ventures, increased visibility of children's services, enhanced case management, and strong legislative support are the main strengths (Isaacs, September 1984, pp. 7-8).

Formal Coordinating Mechanisms. With this approach, no new single agency is formed. Instead, a separate commission is designated to coordinate those agencies responsible for planning and providing children's services. This commission might be a new division within an umbrella agency, or it might be a less structured council of department heads or commissioners that meets to coordinate the activities of the different agencies. Georgia, Maine, New York, Massachusetts, Mississippi, Missouri, New Mexico, Ohio, Oklahoma, and South Carolina employ this method of coordination. They report in general that this approach allows departments to retain their identity while it enhances coordination. Furthermore, the presence of "an objective neutral force" has been positive. Unfortunately, there still remain certain problems. Turf issues are not fully resolved with this approach, and the lack of funding impedes the implementation of needed changes. Furthermore, a lack of real control over the departments involved sometimes perpetuates the ongoing problem that each department is self-contained (Isaacs, September 1984, pp. 10-17).

Discussion. While each of these approaches has its own merits, all three address in part the policy and planning issues present in fragmented children's services. By providing a focal point for discussion, the issues become more visible to both government leaders and to the public. In summarizing the three approaches, Isaacs said that while loss of power is a real fear for mental health representatives entering such coordinating systems, it seems likely that its influence will grow as mental health services become an integral concept in treatment intervention for all children and their families. For example, a child welfare philosophy is not "necessarily incompatible with a mental health philosophy as long as neither is rigidly or narrowly defined" (Isaacs, September 1984, p. 19). When coordinating mechanisms have more control over funding, success will be more evident. Lack of resources can impede even the most brilliant of plans, and concrete change must be seen by those working together in order for them to continue with that approach.

Community Collaboration

If the underlying value of the CASSP initiative is to provide care that is community-based, then the ultimate goal of coordination of services is that which takes place at the community level. In A System of Care for Emotionally Disturbed Children and Youth, Stroul and Friedman stated that the development of systems of care in local communities is the objective of all other strategies because local communities have the ultimate responsibility for serving SED children: "States may adopt strategies that provide communities with not only the responsibility, but the flexibility and decision-making authority to create systems of care that are responsive to their needs and are in all respects community-based" (p. 130).

In A Community Workbook for Developing Collaborative Services for SED Children (Magrab et al., March 1985), the authors maintained that the first step in any community cooperative effort is to establish a concrete goal for action. Failure of such efforts is often attributable to a "lack of clarity and shared understanding" of objectives (pp. 1-2). The authors suggested the following as a possible, concrete goal that could serve as the guiding force in a community's efforts to coordinate services:

> To develop a community-based, collaborative service delivery system for children with serious emotional disturbance and their families that provides every child diagnosed as seriously emotionally disturbed with a written and operational individualized plan that addresses educational/recreational,health, mental health, housing/shelter, and other social service needs. (p. 1)

Once such a major goal is agreed upon, three interim goals were suggested. A network of communication should be established. Anytime two or more agencies are intervening in the life of a child or family, communication is critical. Additionally, a tracking system should be in place that assures that no child requiring treatment will "fall through the cracks." And finally, a regular forum should be established to discuss procedures and policies and to resolve any possible conflicts. Before a community can proceed with a plan of action, there is a need for communities to define their target population and to determine their needs, as well as to survey service providers and determine where the gaps exist (Magrab et al., March 1985, p. 2).

As Isaacs indicated that action is essential to successful state coordination, the authors here maintained that successful community coordination requires concrete action with visible results. All members of the team should participate in the planning process, with particular emphasis placed on identifying priorities to be achieved and possible barriers to success. Strategies then are generated and action will proceed (pp. 26-28). It appears that the dynamics of the group, their persistence and willingness to work together, will largely determine the outcomes.

Action on the local level occurs in various ways. Joint referral is usually an important first step, with programs taking referrals from more than one source or, in some cases, from an interagency group set up to screen referrals. Interagency advisory groups might be set up to not only select and refer clients to various community programs, but also to conduct follow-up and evaluation. Ideally,.community collaboration should lead to cross-system planning, training, and advocacy, unified assessment procedures, and joint funding of programs (Knitzer, 1989, pp. 11-13).

CASSP: A MODEL FOR TEXAS

Bringing CASSP to Texas

In 1987, largely in response to the growing concern for children's mental health issues, Senate Bill 257 of the 70th Legislature directed TDMHMR to establish the position of Coordinator of Children and Youth Services. Such a focus had been sorely lacking within the department and had been strongly advocated by the Task Force on Mental Health Services for Children and Mental Health. Dr. Reginia Hicks, who was employed by TDMHMR as a Child/Adolescent Program Specialist, was hired as the Coordinator of Children and Youth Services in February 1987. Responsible for training, interagency coordination, and policy development for children's and adolescent's mental health programs, Hicks saw that the climate in Texas was becoming quite favorable for change. Increasing emphasis on the development of services for multiproblem children, as well as legislative mandates for interagency collaboration, pointed the way to the application for CASSP funding and the assistance it would provide (TDMHMR, 1988, pp. 1-2).

The CASSP grant proposal was submitted by the Division for Children and Youth Services at TDMHMR to the Department of Health and Human Services for funding in 1988. The budget request was for $174,825. A State-Level System-Development Project was proposed to "enhance the Texas Department of Mental Health and Mental Retardation's efforts toward improving the delivery of services to severely emotionally disturbed children and adolescents" (TDMHMR, 1988, p. 3). The proposal outlined a CASSP program unit, to be established within the Division of Children and Youth Services, with staff consisting of four full-time members (a project director, two regional coordinators, and one secretary); in addition the coordinator of Children and Youth Services was to contribute 50 percent of her time to project-related activities. Staff responsibilities, which were clearly delineated in the proposal, included "assessment, planning, program evaluation interagency liaison/coordinating, technical assistance, and community consultation" (TDMHMR, 1988, p. 16). Project goals, consistent with overall CASSP philosophy, were outlined as follows:

1. To increase awareness of service needs as well as necessary funding requirements for SED children.
2. To improve interagency cooperation in providing these services.
3. To increase awareness within TDMHMR and promote the development of a statewide continuum of care for children and youth.
4. To improve funding accessibility and utilization for the CASSP population.
5. To develop a management information system, including demographic, diagnostic service need, and follow-up information on the CASSP population.
6. To advocate for state, legislative, and community support for the CASSP activities.

7. To provide technical assistance to those serving the CASSP population. (TDMHMR, 1988, p. 20).

Although the proposal outlined 11 major objectives in meeting these seven stated goals, five key components were emphasized: the formation of a CASSP Advisory Task Force (comprised of many of the same key officials participating in the State Coordinating Committee on Multi-Problem Youth) which would work toward community and statewide support for CASSP; identification and assessment of the target population; case management; advocacy and support; and technical assistance. A three-year Plan of Action was submitted in the proposal which emphasized these components (Appendix 11.6).

A CASSP state-level grant in the amount of $150,000 was awarded to TDMHMR in the fall of 1988 to enhance the development of a comprehensive child and adolescent mental health system in the state of Texas (McKimmey, 1989). A second state-level grant for $174, 825 was awarded in 1989. Gerry McKimmey, M.S.W., hired in December of 1988, is the program director of the CASSP project. Two regional coordinators, Cathy Dukes, M.S.W., and Shirley Rendon, M.S.W., work out of the San Antonio and Terrell state hospitals respectively. A secretary completes the project staff (McKimmey, 1989). Reginia Hicks, coordinator of Children and Youth Services at TDMHMR, devotes 50 percent of her time to CASSP-related activities. All mental health regions of the state are assigned to one of the CASSP staff for purposes of the project. On January 11, 1989, the Children and Youth Services Coordinating Committee of THHSCC voted to act as the statewide advisory group for CASSP activities. This group contains key personnel from the various state agencies which serve the target population,as well as representatives from the private sector and advocacy groups (McKimmey, 1989).

Major CASSP Efforts

Children and Youth Demonstration Project. Dr. Reginia Hicks has stated that perhaps the most vital contribution of CASSP in the overall development of improved services for SED children would be to create a climate for change in the state of Texas (Interview, September 26, 1989). Such a change was evidenced by the appropriation of $2 million during the 1990-91 biennium for the expansion of community mental health services to children and youth. The appropriated funds were allocated to community programs through a Request for Proposal (RFP) procedure. On November 7, 1989, Dennis R. Jones, commissioner of TDMHMR, directed a letter to the superintendents of state facilities, the directors of state centers, and the executive directors of MHMR centers concerning the RFPs for this funding. He stated that

> the planning and implementation of an appropriate system of care for children and youth must reflect the key role of our Department in financing services and initiating policies that foster the development of collaborative programs with other agencies. These new endeavors will also enhance the state-community partnership necessary for the creation of a continuum of services This will include shared funding of community programs, as well as community support of state-initiated interagency agreements. (Letter, November 7, 1989)

It is important to note that this $2 million appropriation provides additional funding; according to Senate Bill 222, Article II, appropriated monies "shall not supplant the fiscal year 1989 level of funding expended by each community mental health center for mental health services for children and adolescents, but shall be in addition to it" (TDMHMR, November 1989, p. 1).

In accordance with CASSP philosophy, the stated goal of the Children and Youth Demonstration Project is "to expand the provision of appropriate and coordinated mental health services to children, youth, and families at the community level, and decrease reliance on the use on inpatient hospitalization and long-term residential treatment" (TDMHMR, November 1989, p. 3). To achieve that goal, site applicants were advised to develop procedures for interagency collaboration, procedures for parent involvement, and those services necessary to achieve a continuum of services for SED children and their families, as funds would be awarded to those sites that best demonstrate a commitment to these objectives (TDMHMR, November 1989, p. 3). Furthermore, applicants were asked to demonstrate a clear understanding of the continuum of community-based mental health services and to identify both currently available services as well as suggested expanded services. The existing level of services would be compared with the ideal continuum, which would include such services as therapeutic foster homes, day treatment, and case management.

Although TDMHMR recognized that this funding would not be sufficient to develop a full continuum of services (rather, the funding was viewed as an incentive to community mental health centers to expand community services for children and adolescents), sites were encouraged to develop those services necessary to maintain youth within the community setting. Funds could not be used for inpatient hospitalization, and alternative treatments were advised (TDMHMR, November 1989, pp. 1-3). A line item budget and budget narrative for the initial grant period, March 1, 1990- August 31, 1990 (as well as for the second year of the grant period, September 1, 1990-August 31, 1991) was also required with the application. In the Overview of the Budget Guidelines, applicants were advised that those programs which can demonstrate community support through in-kind contributions would be considered favorably in the review process.

In an attempt to fund sites that were broadly representative of rural and urban areas in Texas and based largely on state population figures, all community mental health centers, state centers, and state hospital community programs were assigned to one of four groups. The deadline for grant proposals was January 10, 1990. Thirty applications were received and on February 15, 1990, a grant was awarded in each of these four categories as follows: $625,000 to Dallas County Mental Health and Mental Retardation Center (Category I), $500,000 to Austin-Travis County Mental Health and Mental Retardation Center (Category II), $375,000 to Sabine Valley Center (Category III), and $250,000 to Rio Grande State Center Community Services (Category IV), for a total of $1.75 million (Levins, February 1990). Funding began in March of 1990. Sites will receive $100,000 for planning, program development, and service implementation during the first year; any unencumbered funds can be carried over into the second year (TDMHMR, November 1989, pp. 2, 5).

All four of the selected sites emphasized interagency collaboration and in-home services in their proposals for funding. The proposal submitted by the Dallas County MHMR center outlines a plan for multiagency case coordination which includes the Dallas County Child Protective Services, Dallas County Juvenile Department, Dallas Independent School District, and the Child and Adolescent Staffing Team. The interagency plan stresses better access to services for families as well as improved identification of families in need. The Dallas proposal for services includes a day treatment program for severely emotionally disturbed children (and their families) as well as a family in-home support program aimed mainly at youth at risk of hospitalization or residential treatment (Levins, February 1990).

The Austin-Travis County MHMR center plans to involve ten different agencies in its project through interagency and family conferences. The project, which will be called the Family Preservation Program, includes services aimed at decreasing reliance on institutional care for emotionally disturbed youth. Home-based crisis intervention will be provided to families experiencing a crisis situation, and in-home support services will be offered to families who have a history of instability and inability to manage the disturbed child at home. In addition, up to ten hours of respite care will be available for families.

All three services are innovative approaches which recognize the value of preserving the family unit (Levins, February 1990). The Austin-Travis County center estimates that the number of Travis County youths admitted to the state hospital could be reduced from 167 to 67, and that the length of their hospitalization could be cut in half (Gamino, 1990, p. B2). John Brubaker, executive director of the center, emphasized that this is not a "come-back-to-the-office kind of program" and that in working with some of the most "damaged" children in the county, the program will be most helpful (Gamino, 1990, p. B2).

Interagency coordination for the Sabine Valley Center project will be accomplished through the efforts of the Coordinating Regional Council and the Texas Network for Children. In-home crisis intervention services will be provided, with the family unit being the focus of these services. Furthermore, case managers will be trained to provide services to multineed youth through a multiagency model, and a multidisciplinary diagnostic staff will be added at the center. Finally, the number of therapeutic foster home placements will be increased, and they will be especially used for short-term respite care and crisis intervention (Levins, February 1990).

The Rio Grande State Center Community Services will establish advisory councils in each of the five counties in its service area. Representatives from special education, juvenile probation, child welfare, the courts, private providers, and the consumers themselves will work out referral agreements and recommendations for services. A family preservation model proposes to deliver home-based mental health services to emotionally disturbed children and their families, with particular emphasis on unserved populations (Levins, February 1990).

Key Informant Surveys. First-year CASSP goals included the development of the CASSP focus within TDMHMR, the identification of the target population, and the assessment of needs within the communities. Key informant surveys have been conducted by CASSP staff who have visited the 35 community mental health centers in the state, the seven state hospital community programs, and the three state centers which provide community-based services through TDMHMR The purpose of the visits was to "obtain a detailed accounting of the service delivery system in each of the areas, establish working relationships with key staff, and determine strategies for increasing needed services" (McKimmey, 1989, p. 1). According to regional coordinator Shirley Rendon, who conducted many of the surveys, these surveys will help identify service gaps as well as resources and needs of the CASSP population. Ms. Rendon said that these face-to-face interviews have been an important tool, not only in terms of assessment but also as a means of introducing CASSP to areas where in many cases, no focus for children exists. Furthermore, she sees real possibilities emerging for the development of advocacy, both with parent and professional groups (Rendon, Telephone interview, September 29, 1989). The surveys were completed at the end of October 1989 and are in the process of being analyzed (see Chapter 4).

Parent Support and Advocacy. A major focus for CASSP's first year of operation has been parent support and advocacy. Just as the national CASSP effort emphasizes that family input and support is a vital component of the system of care, parental input will be actively sought and supported in the Texas effort.

Three "Families as Allies" conferences have been held in Austin, Houston, and Corpus Christi. Families as Allies is a movement supported largely by the Research and Training Center at Portland State University. CASSP training materials are utilized and the conferences provide an important forum for parents of SED children. Such parents, unlike parents of children with other handicaps, have not traditionally had an opportunity to discuss their needs and concerns. These conferences are being cosponsored by TEA, and plans are to continue providing these conferences around the state (McKimmey, 1989, p. 2).

There have been other efforts in this area of parent advocacy as well. Approximately 40 parent advocates as well as professionals from mental health, juvenile probation, and local school districts participated in an Expert Forum in Conroe on September 9, 1989. This forum focused on strategies for increasing parent advocacy and support statewide. The CASSP office has been working closely with the Texas Alliance for the Mentally Ill (TEXAMI) by providing funds and technical assistance for the development of ten statewide Child Adolescent Network (CAN) groups, as well as by sponsoring a parent delegate to a national conference on parent advocacy. In addition, the CASSP office has been collaborating with MHAT on a statewide plan for parent involvement, working to ensure especially that parent support, training, and information will be available in the four selected demonstration projects (McKimmey, 1989, p. 2).

Interagency Efforts. In an effort to promote interagency coordination, CASSP, along with TEA and DHS, has been involved in a series of workshops and training sessions on suicide intervention for teens. Thirteen rural counties, where the incidence of teen suicide is higher than average, have been selected for the project. Cross-training of workers from mental health, schools, DHS, and juvenile probation has been encouraged, with community teams meeting and formulating interagency plans for crisis intervention and response to possible suicides and other emergencies (McKimmey, 1989, p. 3).

Gerry McKimmey, CASSP project director, reported in his March 1989 update that "CASSP response to interagency requests for problem resolution has been occurring on a regular basis" (p. 3). The CASSP regional coordinators, who operate out of Terrell and San Antonio state hospitals rather than the state office, have established important contacts and visibility throughout the Key Informant Survey process. Frequently, in cases involving children affected by other agencies (such as TEA or TDHS) in addition to TDMHMR, the coordinators are called upon to clarify the roles and responsibilities of the local MHMR provider. Such cooperation facilitates the delivery of care for children and their families.

Training Efforts. To date, CASSP has sponsored staff from two community mental health centers to attend two weeks of intensive training at the Family Preservation Institute at Rutgers University. These delegates will serve as consultants to TDMHMR in the techniques of intensive home-based intervention. Similarly, a delegate was sponsored to a national respite care conference in November 1989 and will act as a consultant to TDMHMR on respite care for the child and adolescent population. Other accomplishments include the development of a four-part series on child and adolescent issues to be used for staff development at TDMHMR (McKimmey, 1989, p. 3).

CASSP-LIKE EFFORTS

The CASSP focus at TDMHMR was established as recently as December of 1988. The philosophy that guides the CASSP effort has been steadily evolving, not only at the federal level, but here in Texas as well. Interagency coordination has been a goal, if not a reality, for probably 20 years (Austin and Michie, September 1989, p. 4)! The need for intensive community-based interventions has been established, not only by TDMHMR, but also by TDHS, TYC, and TJPC. The language that pervades the CASSP literature, the call for a continuum of services that is family-based and child-centered, does not belong to CASSP alone--it is found frequently in the literature of all those agencies that serve SED children. Certain programs and projects, established before CASSP or without the direct involvement of CASSP, merit attention as they especially demonstrate CASSP goals.

Community Resource Coordination Pilot Project

The whole philosophy of interagency cooperation got a headstart in Texas in 1983, with Senate Bill 711, a Mandate to Coordinate. As a result of this legislation, the Texas Health and Human Services Coordinating Council was formed to serve as the primary state resource in coordinating and planning for health and human services. In 1987, children's mental health issues became a source of increasing concern. Senate Bill 298, during the 70th Legislative Session, established the Children and Youth Services State Coordinating Committee as part of THHSCC. In October of 1989, this committee became part of a new commission, the Commission on Children, Youth, and Family Services (Austin and Michie, September 1989, p. 5). Senate Bill 298 further mandated interagency collaboration by requiring a Memorandum of Understanding between those state agencies delivering services to multiproblem children. This memorandum provided for the implementation of a system of community resource coordination groups to ensure the coordination of services between agencies for multiproblem children. Furthermore, the memorandum stressed the importance of the family as an "integral part of each child's or youth's support system" and the commitment of the agencies to offer services in "the most normal and least restrictive environment possible" (Tex. S.B. 298, 1987, p. 1).

The Community Resource Coordination Group (CRC) is basically viewed as a staffing model, which works to facilitate an agreement between agencies for coordination of services for multineed children and which works to "implement, monitor, and evaluate" those agreements (Performance Resources, Inc., October 1989, p. 4). Four counties in Texas, Val Verde, Henderson, Travis, and Tarrant, were selected as demonstration sites for this project. Performance Resources, Inc., a private consulting firm, was selected to implement and evaluate the project, which was begun in December 1988.

Representatives from the following agencies were asked to participate in the CRC: Texas Department of Human Services; Texas Department of Mental Health and Mental Retardation; Texas Department of Health; Texas Youth Commission; County Juvenile Probation Department; Texas Rehabilitation Commission; Texas Commission for the Blind; and Texas Education Agency. In addition, representatives from the private sector were asked to participate (Performance Resources, Inc., October 1989, p. 4). All of the above agencies, as directed by a Memorandum of Understanding which said that all parties were of good faith and would act together, have contributed $6,000 each toward the fee for Performance Resources, Inc. (Olson, October 1989).

An initial effort was made to find out which agencies had prior experience in interagency coordination. Building on these findings, Performance Resources provided orientation and training for participants in the spring of 1989 as well as a second training session in the summer. The first staffing was held in Travis County in March 1989. CRC staffing data, completed January 11, 1990, indicated that Travis County has reviewed 9 cases; Tarrant County has reviewed 13 cases; Henderson County has reviewed 6; and Val Verde has staffed 4 cases (Performance Resources, Inc., 1990). A possible reason for this disparity is that agencies in the rural areas had been working more on a one-to-one basis prior to participating in the CRC and were not as accustomed to the concept of interagency coordination as were agencies in Travis and Tarrant counties (Romig, October 1989).

Performance Resources is also responsible for the evaluation of the CRC project. Initial results showed that the experience and training has provided valuable opportunities for sharing resources and information about services. Data completed in January 1990 on agency follow-through showed that for the 32 cases staffed to date, services have been provided by 38 different organizations, with the bulk of the services rendered by TDMHMR and TDHS. In all but five situations, services were provided as determined by the CRC staffing, and where this occurred, either the client's situation had changed or the client had moved. According to the CRC data, services of some kind were offered but refused by the client on 14 occasions, and except in cases where the information was not completely available, the remaining services were provided as agreed upon at the original staffing (Performance Resources, Inc., 1990). When CRC liaisons were asked if difficult to manage youths were the priority youths for staffing during this first year, 95 percent of the 42 respondents answered yes (Performance Resources, Inc., 1990). However, certain challenges to the project have surfaced as well. Case workers need to be trained as to which cases are most appropriate for such interagency staffings (Romig, October 1989). Furthermore, as cases are staffed, more emphasis needs to be placed on the whole family and not just on the individual child. Once a case has been staffed, accountability for that case needs to be well established (Olson, October 1989).

Begining in FY 1991 the CRC project has been extended five more years and added 15 more sites throughout the state. The counties that will be added to the CRC project include

1. Armstrong/Potter/Randall
2. Atascosa/Frio/Karnes/LaSalle
3. Bandera/Gillispie/Kendall/Kerr
4. Bexar
5. Bowie
6. Brewster/El Paso/Jeff Davis/Presidio
7. Ector/Midland
8. Hidalgo/Cameron
9. Hunt
10. McClennan
11. Nacadogches
12. Rockwall
13. Taylor
14. Webb/Zapata
15. Wichita (McKimmey, 1990b).

It is hoped that the CRC project will be statewide so that all of the children and adolescents with multi-agency needs can be served.

Intensive Family Intervention

In 1987 alone, TDHS conducted 67,000 investigations of alleged abuse or neglect. Additionally, TDHS received numerous other reports of situations where abuse or neglect had not occurred, but where the potential for such problems was present. These at-risk situations frequently involved parents with behaviorally disturbed children, and families were generally referred by TDHS to community resources for help. In 1987, a Joint Study Group was established by TDHS, along with TDMHMR, TJPC, TEA, TYC, and several private-sector human service agencies, to discuss the special problems of families with behaviorally disordered children. The study group, in investigating the situation, confirmed that such community services were generally inadequate, particularly for families whose children were at risk of out-of-home placement, or whose children might be returning to home after an out-of-home placement. Family preservation or reunification, while expressed as a goal, was not in fact backed up by the home-based services necessary to prevent dissolution. The study group developed a Memorandum of Understanding which outlined plans for coordinating and developing a continuum of services within the community. The agencies agreed that existing community mental health facilities would be the logical vehicle for providing such services to families with behaviorally disturbed children (McDaniel, May 1989, p. 1).

A project was jointly proposed by TDHS and TDMHMR entitled Intensive Family Intervention for Behaviorally Disturbed Children (IFI). The project plans to "implement a demonstration that will allow TDMHMR and DHS to provide intensive home-based services (1) to families with behaviorally disturbed children who are at risk for out-of-home placement or (2) to families with children already placed outside the home who need assistance to ensure their return (McDaniel, May 1989, p. 2). TDHS is the grantee, and under contract with that agency, TDMHMR will provide the treatment and intensive home services through the local mental health authority. The two areas with the state's highest concentration of population under the age of 17 have been selected as demonstration sites: Harris County has been selected as an urban demonstration site, and the Lower Rio Grande Valley (Tropical Texas) as a rural area. Funding for the project has been approved for February 1, 1989, through January 31, 1991.

The expressed goal of the project is twofold. Collaborative mental health and child protective services will be established "to reduce the number of children who will become part of the child welfare system because of their families' inability to cope with behaviorally disturbed adolescent(s) and to assure successful return of behaviorally disturbed adolescents to their family of origin from out-of-home placements" (McDaniel, May 1989, p. 2). Objectives of the project will be to develop at both sites a system of identification and referral of families with at-risk youngsters; to provide intensive home-based mental health services to 120 families (60 per year) with behaviorally disturbed adolescents at risk of placement outside the home; to develop and implement a system of respite care for adolescents at risk of placement outside the home; and to provide respite care and home-based services to families with disturbed youngsters who have been placed outside the home in order to facilitate their return (McDaniel, May 1989, p. 2).

Project staff agreed on the target population of adolescents between the age of 12 and 17 whose behavior is verbally abusive and threatening, aggressive or violent, or sexually inappropriate, who are exhibiting difficulties in school, who are initial (not chronic) runaways, and whose problem is not primarily substance abuse. Based on these guidelines, staff developed screening and referral criteria for youths at risk of placement or ready for discharge, as well as referral criteria for parents. In order for the two sites to offer the most effective treatment, the decision was made for Houston to focus its efforts on providing services to those youths returning to their home from placement, and for Tropical Texas to focus its efforts on providing home-based services to families with adolescents at risk of placement (McDaniel, May 1989, pp. 3-4).

Existing staff will be trained to screen all referrals. Both crisis and long-term services are anticipated. Respite care, a major objective of the program, will be provided by the Chimney Rock Center in Houston and by the Youth Crisis Center in Edinburg. These two organizations will provide as grantee match one respite care bed each for 365 days for each year of the project. Houston, working especially toward reunification, will utilize its beds "to aid in the transition of bringing the youth from an institutional setting back to the family" and to "allow a more orderly, smooth integration, while minimizing the chances of disruption." Tropical Texas, working to prevent placement outside the home, will use its respite beds as a "safety valve" for youths during the treatment process (McDaniel, May 1989, p. 5).

Several issues have emerged as this project has developed. The need for intensive home-based services to these families remains critical. There is a need to determine how many such behaviorally disturbed children there are at the two sites as well as how many dollars might be saved and how many problems might be avoided if intensive home-based services were offered to these youngsters early on. Education about the project and its findings is considered critical. A process evaluation plan has been established which includes information about the processes necessary to complete each project objective. The evaluation includes such questions as how many families were referred to IFI; what the barriers to referral were; how many families received in-home services; which kinds of in-home services were provided; how successful services were in maintaining the adolescent in the home; and so on. The final process evaluation plan will be disseminated nationally and will serve as a useful guide to those who wish to duplicate the IFI project. To determine whether the objectives have been met, data will be analyzed on products of the project, interviews with the staff, participation in planning, site visits, and monthly reports (McDaniel, May 1989, p. 6 and Appendix C).

Case Management

Because case management is considered such a critical element of a successful CASSP system of care, it is worth noting that there are two community mental health centers here in Texas (Dallas and San Antonio) that have been able to use this method of treatment for SED children. Irene Alverado, director of case management for children at the Bexar County Community Mental Health Center in San Antonio, says that although no money is actually earmarked for children's case management through TDMHMR funding, Bexar County has two workers who specialize in case management for children. This program has been in existence for approximately three years, and case management, as the "catalyst" that brings it all together, unequivocally improves the situation for children (Interview, September 27, 1989). Although 30 is considered a standard case load, case managers working with children generally carry no more than 15 to 20 cases at a time. While the child is the client, it is impossible to separate the child's needs from the family's needs. Alverado suggested that it is this holistic view which makes case management so particularly valuable for SED children. Limited funding has forced Bexar County to use case management for the priority population of children coming out of state hospitals--those who are in the system already. Bexar County hopes to increase its number of workers and to move toward providing services for those children "at risk" as well.

Joanne Brechtol, director of case management for Community Mental Health Programs at San Antonio State Hospital, does not have case managers specifically assigned to children. Because case managers in this outreach program must service such large regions, each case manager receives special training to be able to appropriately service those children on case loads. At this time, each of 11 case managers has approximately 35 clients, and 2 or 3 children are part of each case load. Only those children who demonstrate multiple problems of a severe nature, for at least a six-month period, are served. Brechtol echoed the sentiments of Alverado, and said that case management for children opens the doors and links the systems for total support of a child and his or her family (Interview, September 28, 1989).

CONCLUSIONS

CASSP is the major federal thrust for attending to the problems of seriously disturbed children and their families. CAASP, which uses a system-of-care approach, is guided by the principles that this system should be child-centered and community-based. The program, while stressing that all types of mental health services should be available, does advocate for an increase in the less restrictive alternatives to residential treatment. The CASSP approach relies heavily on interagency collaboration and case management as ways of wrapping needed services around multiproblem SED children. CASSP provides technical support which has guided states in the process of setting up a system of care for SED children and, in many cases, has been responsible for providing the incentive and climate for such programs to be established. Furthermore, advocacy and parent support, two essential features of CASSP, are necessary to ensure its future. Once the CASSP focus is in place and once the need for such a child-centered system of care is established, there remains the tremendous challenge to fund the services which will flesh out the system as it is envisioned.

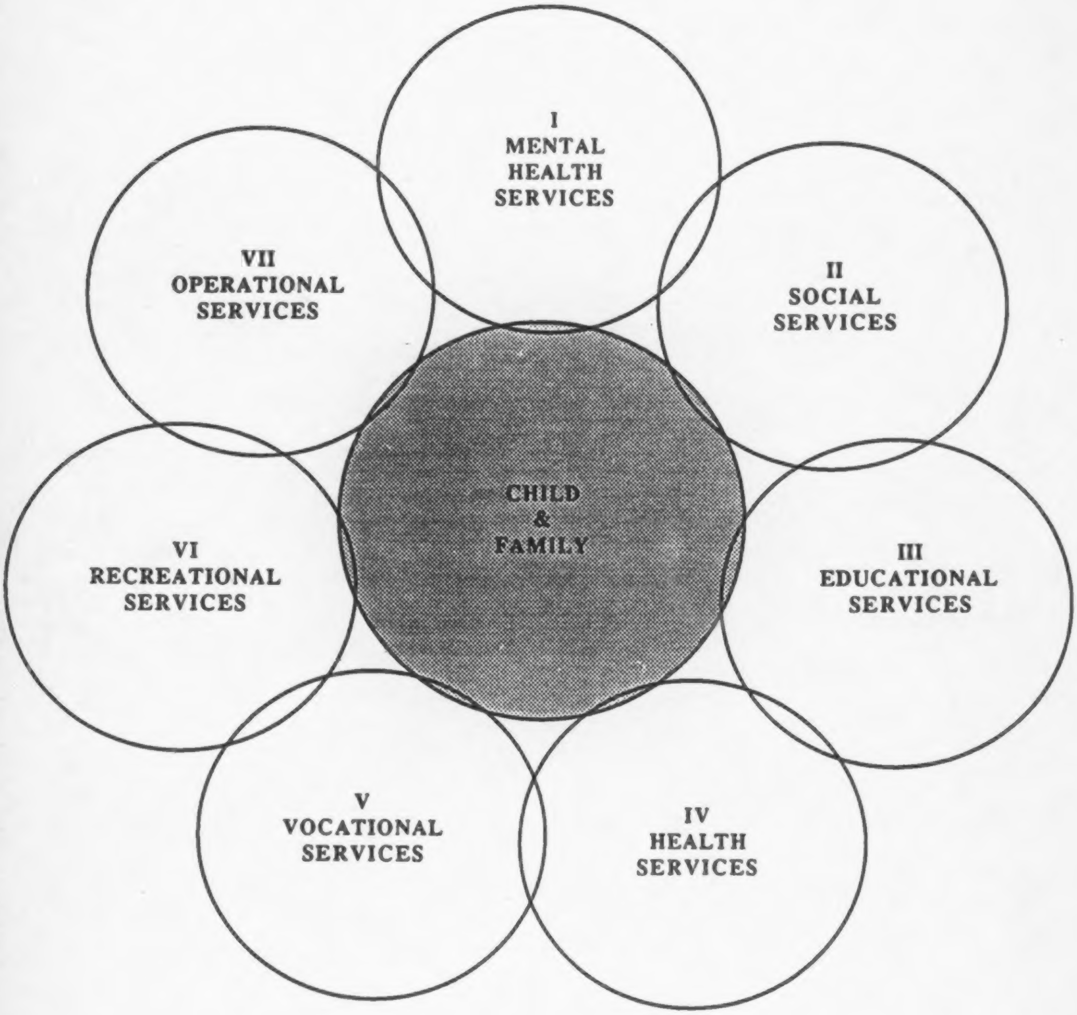
Community-based mental health services for SED children have repeatedly been identified as a monumental need in the state of Texas. The federal CASSP program has identified certain community services not only as vital components of the continuum of care, but also as viable treatment alternatives to restrictive residential care. These services, especially home-based services, crisis intervention (or emergency shelters), day treatment, and therapeutic foster care, over and over, seem to be the very services which are lacking or inadequately supplied by the public sector for SED children in Texas. The climate for change seems to be encouraging, however, and the CASSP focus in place at TDMHMR should provide an additional incentive and impetus in Texas for an improved system of care for SED children and their families.

Appendix 11.1. 1989 CASSP Budget Data: State Grants

State	Grant Number	Renewal Date	Cum. Prior Yr Awards	Prev. Year Award	FY 89 Est.	FY 89 Basic Award	FY 89 Indirect Cost	FY 87 Remainder	FY 89 Admin. Supp.	FY 89 Total Award	Total Award To Date
AK-Kodiak	43568-03	01-Sep-89	200,000	100,000		100,000				100,000	300,000
Arkansas	44471-02	01-Sep-89	52,200	52,200		52,500	2,310			54,810	107,010
California	44469-02	01-Sep-89	167,738	167,738		179,000				179,000	346,738
Delaware	41009-05	01-Jul-89	583,329	139,059		125,000				125,000	708,329
Dist of Col	42421-03	01-Jul-89	214,382	101,566		101,807	7,718			109,525	323,907
GA-SE Region	42372-03	01-Dec-88	200,000	100,000		140,450				140,450	340,450
Idaho	41020-05	01-Jul-89	590,000	140,000		140,000	8,803			148,803	745,803
Indiana	39894-05	01-Sep-89	588,558	140,000		159,545	2,872			162,417	750,975
KY-Appalachi	43675-03	01-Se[-89	175,000	100,000		100,000				100,000	275,000
Kentucky	41005-05	01-Jul-89	589,427	140,000		125,000				125,000	714,427
LA-Baton Rou	43546-03	01-Sep-89	200,000	100,000		100,000	4,400		15,420	119,820	319,820
Louisiana	41021-05	01-Jul-89	577,904	140,000		182,116	8,013			190,129	768,033
MS-Local	44462-02	01-Sep-89	100,000	100,000		116,700				116,700	216,700
Maryland	44497-02	01-Sep-89	150,000	150,000		150,000			30,418	180,418	330,418
Missouri	44459-02	01-Sep-89	113,078	113,078		150,000			42,905	192,905	305,983
N. Carolina	44481-02	01-Sep-89	134,611	134,611		139,163	12,859		29,440	181,462	316,073
N. Hampshire	44494-02	01-Sep-89	47,398	47,398		50,030	2,552			52,582	99,980
Nebraska	39884-05	01-Jul-89	582,000	140,000		150,000				150,000	732,000
OK-Local	43630-03	01-Sep-89	191,800	91,800		90,000				90,000	281,800
Oklahoma	41030-05	01-Jul-89	590,000	140,000		146,000				146,000	736,000
Oregon	44478-02	01-Sep-89	159,000	159,000		179,516				179,516	338,516
PA-Phil	44457-02	01-Sep-89	150,000	150,000		0				0	150,000
Pennsylvania	40145-05	01-Sep-89	590,000	140,000		150,000				150,000	740,000
S. Dakota	44477-02	01-Sep-89	150,000	150,000		150,000				150,000	300,000
SC-Greenvill	43557-03	01-Sep-89	175,176	100,000		133,657	6,683			140,340	315,516
Tennessee	41038-05	01-Aug-89	474,549	140,000		145,000				145,000	619,549
Texas	44475-02	01-Sep-89	150,000	150,000		174,825				174,825	324,825
Utah	44464-02	01-Sep-89	52,200	52,200		52,500	2,310			54,810	107,010
Vermont	39882-05	01-Apr-89	590,000	140,000		122,900	2,100			125,000	715,000
Virgin Isl.	42384-03	01-May-89	197,016	112,400		100,087	8,115			108,202	305,218
Illinois	41016-04	01-Dec-88	430,999	0		149,693				149,693	580,692
Iowa	42370-04	01-Sep-89	315,387	106,000		170,000				170,000	485,387
KS-Wichita	45376-04	01-Sep-89	300,000	100,000		0				0	300,000
MA-HHP	43699-03	01-Sep-89	264,760	142,714		164,157	6,253			170,410	435,170
NY-Brooklyn	42415-04	01-Sep-89	351,000	117,000		223,211	10,874			234,085	585,085
New York	41011-04A1	01-Aug-89	500,000	25,000		207,500	3,795			211,295	711,295
Virginia	42418-04	01-Sep-89	294,906	114,216		180,000			33,016	213,016	507,922
W. Virginia	41014-04	01-Jul-89	437,000	150,000		168,850	2,025			170,875	607,875
Washington	41018-04	01-May-89	426,320	150,000		180,000				180,000	606,320
Alabama	46298-01	01-Aug-89	595,743	125,000		29,278				29,278	625,021
Alaska	43568-01	01-Jul-89	725,000	125,000		0				0	725,000
Georgia	46749-01	01-Aug-89	721,234	125,000		9,595				9,595	730,829
Hawaii	46384-01	01-Jul-89	691,094	163,036		0				0	691,094
Kansas	46344-01	01-Jul-89	634,125	125,000		10,000				10,000	644,125
Maine	46329-01	01-Jul-89	727,946	125,000		0				0	727,946
Mississippi	46372-01	01-Jul-89	705,199	125,000		0				0	705,199
New Jersey	46730-01	01-Sep-89	725,000	125,000		0				0	725,000
Ohio	46347-01	01-Jul-89	595,243	125,000		39,999				39,999	635,242
Wisconsin	46388-01	01-Aug-89	659,531	125,000		10,750				10,750	670,281
Arizona	46374-01	30-Sep-89	0	0		158,908	7,897			166,805	166,805
Colorado	46315-01	30-Sep-89	0	0		179,700				179,700	179,700
Connecticut	46356-01	30-Sep-89	0	0		180,000				180,000	180,000
Florida	46299-01	30-Sep-89	0	0		255,000				255,000	255,000
Montana	46332-01	30-Sep-89	0	0		47,646	8,713			56,359	56,359
Nevada	46313-01	30-Sep-89	0	0		170,317				170,317	170.317
New Mexico	46354-01	30-Sep-89	0	0		45,290	4,710			50,000	50,000
NC-Mecklenb	46357-01	30-Sep-89	0	0		130,000				130,000	130,000
N. Dakota	46263-01	30-Sep-89	0	0		0				0	0
Rhode Island	46268-01	30-Sep-89	0	0		63,670				63,670	63,670
Vermont	46319-01	30-Sep-89	0	0		39,000	1,000			40,000	40,000
Wyoming	46390-01	30-Sep-89	0	0		180,000				180,000	180,000
Subtotal			18,835,853	5,824,016	0	6,698,360	114,002	0	151,199	6,963,561	25,799,414
				Residual		14,947					

Source: CASSP Technical Assistance Center, October 2, 1989.

Appendix 11.2. System of Care Framework


I
MENTAL
HEALTH
SERVICES
II
SOCIAL
SERVICES
III
EDUCATIONAL
SERVICES
IV
HEALTH
SERVICES
V
VOCATIONAL
SERVICES
VI
RECREATIONAL
SERVICES
VII
OPERATIONAL
SERVICES
CHILD
&
FAMILY

Source: Stroul and Friedman, July 1986, p. ix.

Appendix 11.3. Components of the CASSP System of Care

1. **Mental Health Services**

   Prevention
   Early Identification & Intervention
   Assessment
   Outpatient Treatment
   Home-Based Services
   Day Treatment
   Emergency Services
   Therapeutic Foster Care
   Therapeutic Group Care
   Therapeutic Camp Services
   Independent Living Services
   Residential Treatment Services
   Crisis Residential Services
   Inpatient Hospitalization

2. **Social Services**

   Protective Services
   Financial Assistance
   Home Aid Services
   Respite Care
   Shelter Services
   Foster Care
   Adoption

3. **Educational Services**

   Assessment & Planning
   Resource Rooms
   Self-Contained Special Education
   Special Schools
   Home-Bound Instruction
   Residential Schools
   Alternative Programs

4. **Health Services**

   Health Education & Prevention
   Screening & Assessment
   Primary Care
   Acute Care
   Long-Term Care

5. **Vocational Services**

   Career Education
   Vocational Assessment
   Job Survival Skills Training
   Vocational Skills Training
   Work Experiences
   Job Finding, Placement and Retention Services
   Sheltered Employment

6. **Recreational Services**

   Relationships with Significant Others
   After School Programs
   Summer Camps
   Special Recreational Projects

7. **Operational Services**

   Case Management
   Self-Help & Support Groups
   Advocacy
   Transportation
   Legal Services
   Volunteer Programs

Source: Stroul and Friedman, July 1986, p. xii.

Appendix 11.4. The CASSP Mental Health Components of Care

Non Residential Services:	Residential Services:
Prevention	Therapeutic Foster Care
Early Identification & Intervention	Therapeutic Group Care
Assessment	Therapeutic Camp Services
Outpatient Treatment	Independent Living Services
Home-Based Services	Residential Treatment Services
Day Treatment	Crisis Residential Services
Emergency Services	Inpatient Hospitalization

Source: Stroul and Friedman, July 1986, p. xiii.

Appendix 11.5. Model for a Balanced Community-Based System of Services

Services	Proposed Capacity (Per 10,000 Youth)		Proposed Capacity (Per 1,000,000 Youth	Present Capacity (To be completed by planning group)
Residential				
Hospital/RTC (Long-Term)	1		100	
Hospital/Crisis Stabilization	1		100	
TFC/TGH/Wilderness	8		800	
	10		1,000	
Non-Residential				
Home Based	20		2,000	
Day Treatment	20		2,000	
Outpatient	80		8,000	
	120		12,000	
Case Management with Wrap-Around	40		4,000	
Parent Support	(24)	(20% of kids)	(2,400)	
	40			
Total Capacity	170		17,000	
Multiple Services	50		5,000	
Individual Children Served	120		12,000	
Turnover after				
- 6 mos.	240	(2.4% of youth)	24,000	
- 9 mos.	180	(1.8% of youth)	18,000	

Source: Friedman, 1987.

Appendix 11.6. Three Year Management Plan for CASSP

Plan of Action

Management Plan

Timetable

Year 1

- Establishment of CASSP Program Office within TDMHMR.
- Recruit and hire program staff.
- Development of Regional and State Advisory Task Force.
- Develop resource directory for planning purposes.
- Conduct working conference on the dissemination of CASSP information and concepts.
- Initial data collection
- Identification of the target population.
- Development of instrument for needs assessment.
- Collect and analyze data from needs assessment.
- Conduct key informant study.
- Produce preliminary report based on all collected data.
- Design initial strategies to increase CASSP family support and advocacy.

Year 2

- Produce and distribute final report based on identification and assessment data.
- Refine and implement strategies to increase CASSP family support and advocacy.
- Design initial State-wide CASSP Strategy Plan.
- Hold dissemination conference on results of final report.
- Initiate collection of case management information.
- Prioritize legislative actions supportive of CASSP Project.
- Conduct State and four regional technical assistance conferences.
- Develop a plan for case management program.

Year 3

- Development of community-level CASSP project staff.
- Continued fiscal planning and expansion of legislative support to fill service gaps.
- Continued technical assistance through State and regional conferences, and agency consultation.
- Submit case management plan to identified agencies.
- Continue to expand family support and advocacy efforts.
- Sponsor dissemination conference on the status of the development of a comprehensive service delivery system.

Source: TDMHMR, 1987.

References

Alverado, Irene. 1989. Director of Children's Case Management, Bexar County Community Mental Health Center, San Antonio, Texas. Telephone interview, September 27.

Austin, David, and Ida Michie. September 1989. Community Resource Intervention Notebook: Description of the Texas System and State Agencies Serving Children. Community Interventions Task Force of the Commission of Mental Health of Adolescents and Young Adults. Austin, Texas: Hogg Foundation. (Draft.)

Berndt, Debbie. October 1989. "Do Kids Count? How Texas Serves Children and Adolescents with Severe Emotional Disturbance." Austin, Texas: Mental Health Association of Texas.

Brechtol, Joanne. 1989. Director of Case Management, San Antonio State Hospital, San Antonio, Texas. Telephone interview, September 28.

Child and Adolescent Service System Program (CASSP). May 1988. FY'88 Report, Child and Adolescent Service System Program (CASSP). Washington, D.C.: Division of Education and Service Systems.

____________. April 1989. CASSP Project Summary Updates. Washington, D.C.: CASSP Technical Assistance Center.

Donner, Richard, and Glenda Fine. April 1987. A Guide for Developing Self Help/Advocacy Groups for Parents of Children with Serious Emotional Problems. Washington, D.C.: Georgetown Child Development Center.

Friedman, Robert. 1980. An Introduction to Day Treatment for Emotionally Disturbed Children and Adolescents. Tampa: Florida Mental Health Institute.

____________. 1986. Major Issues in Mental Health Services for Children. Tampa: Florida Mental Health Institute.

____________. 1987. Service Capacity in a Balanced System of Services for Seriously Emotionally Disturbed Children. Tampa: Research and Training Center for Children's Mental Health.

____________. 1988. The Role of Therapeutic Foster Care in an Overall System of Care: Issues in Service Development and Program Evaluation. Tampa: Research and Training Center for Children's Mental Health.

Gamino, Denise. 1990. "Travis Mental Center Getting Grant for Youth Program." Austin-American Statesman (February 16).

Goldman, Sybil K. 1988. Community Based Services for Children and Adolescents Who Are Severely Emotionally Disturbed: Crisis Services. Washington, D.C.: CASSP Technical Assistance Center.

Hardy, Ron. 1987. "Satellite Family Outreach Program." Chicago: Kaleidoscope. (Handout.)

Health and Human Services Coordination Council. February 1989. "Needs and Resources Subcommittee Report." In Children and Youth in Texas: A Proposal for Coordinated Services. Austin, Texas.

Hicks, Regenia. 1989. Coordinator, Children and Youth Services, Texas Department of Mental Health and Mental Retardation, Austin, Texas. Interview, September

Inouye, Daniel K. 1988. "Children's Mental Health Issues." *American Psychologist,* vol. 43, no. 10 (October).

Isaacs, Mareasa. July 1984. *Technical Assistance Package for the Child and Adolescent Service Program*. Washington,D.C.: NIMH.

____________. September 1984. *An Analysis of State Administrative Structures for the Provision of Coordinating Services to Children and Youth.* Washington, D.C.: NIMH.

____________. November 1985. *Addressing the Mental Health Needs of the Juvenile Justice Population: Policies and Programs*. Program Summary of a Symposium. Washington, D.C..

Isaacs, Mareasa, and Sybil Goldman. September 1985. *Profiles of Residential and Day Treatment Programs for Seriously Emotionally Disturbed Youth*. Washington, D.C.: Georgetown Child Development Center.

Jones, Dennis. 1989. Commissioner, Texas Department of Mental Health and Mental Retardation. Request for Proposal Cover Letter, November 7.

Knitzer, Jane. 1982. *Unclaimed Children.* Washington, D.C., Children's Defense Fund.

____________. 1988. "Children's Mental Health: The Advocacy Challenge 'And Miles to Go Before We Sleep.'" In *Advocacy on Behalf of Children with Serious Emotional Problems,* ed. Robert Friedman et. al. Springfield: Charles Thomas Publishing.

____________. 1989. "Collaborations Between Child Welfare and Mental Health: Energizing Patterns and Challenges." Paper presented to Changing Services for Children Project. New York: Bank Street College of Education.

Knitzer, Jane, and Elizabeth Cole. 1989. *Family Preservation Services: The Program Challenge For Child Welfare and Child Mental Health Agencies*. New York: Bank Street College of Education.

Levins, Tracey. February 1990. "Children and Youth Demonstration Project: Proposal Overview." Austin, Texas: Texas Department of Mental Health and Mental Retardation. (Mimeograph.)

Magrab, Phyllis R., et al. March 1985. *A Community Workbook for Developing Collaboration Services for SED Children*. Washington, D.C.: Georgetown University Child Development Center.

McDaniel, Garry. May 1989. *Intensive Family Intervention Quarterly Report: Texas Department of Human Services*. Austin, Texas.

____________. August 1989. *Intensive Family Intervention Quarterly Report: Texas Department of Human Services*. Austin, Texas.

McKimmey, Gerald. March 1989. "Texas CASSP Update." Report to the CASSP Technical Assistance Center. Austin, Texas.

____________. 1989. "Report on the CASSP Project." Austin, Texas.

____________. 1989. CASSP Project Director, TDMHMR, Austin, Texas. Interview, September 21.

Olson, Tom. October 1989. Coordinator, Health and Human Services Coordinating Council. Presentation to Policy Research Project, L.B.J. School of Public Affairs, Austin, Texas.

Performance Resources, Inc. October 1989. Community Resource Coordination Groups. Austin, Texas. (Handout.)

____________. February 1990. Community Resource Coordination Pilot Project. Austin, Texas. (Follow-up Tables.)

Rendon, Shirley. 1989. CASSP Regional Coordinator, Texas Department of Mental Health and Mental Retardation. Telephone interview, September 28.

Research and Training Center [Portland]. 1989. Focal Point, vol. 3, no. 3 (summer).

Research and Training Center for Children's Mental Health [Tampa]. 1989. Update, vol. 4, no. 1 (winter).

Romig, Laurie. October 1989. Technical Assistance Coordinator, Performance Resources, Inc., Austin, Texas. Presentation to Policy Research Project, L.B.J. School of Public Affairs, Austin, Texas.

Saxe, Leonard, et al. 1988. "Children's Mental Health: The Gap Between What We Know and What We Do." American Psychologist, vol. 43, no. 10 (October).

Stroul, Beth. 1985. Child and Adolescent Service System Program System Change Strategies: A Workbook for States. Washington, D.C.: CASSP Technical Assistance Center.

____________. October 1988. Community Based Services for Children and Adolescents Who Are Severely Emotionally Disturbed: Home Based Services. Washington, D.C.: CASSP Technical Assistance Center.

Stroul, Beth, and Robert Friedman. July 1986. A System of Care for Emotionally Disturbed Children and Youth. Washingtin, D.C.: CASSP Technical Assistance Center.

Texas Department of Mental Health and Mental Retardation (TDMHMR). May 1984. Assessment of Needs: Inventory of Services for Children and Adolescents. Task Force on Mental Health Services for Children and Adolescents Report. Austin, Texas.

____________. 1987. Child and Adolescent Service System Program Grant Proposal. Austin, Texas.

____________. 1988. Child and Adolescent Service System Program Grant Proposal. Austin, Texas.

____________. September 1989. Future Directions for Texas: Comprehensive Community-Based Mental Health Services. Austin, Texas.

____________. November 1989. Request for Proposal: Children and Youth Demonstration Project. Austin, Texas.

Texas Department of Mental Health and Mental Retardation and Texas Department of Human Services. January 1989. Child Abuse and Neglect: The Impact on Texas Children, Families, and Communities and the Need for Treatment Services. A Report to the 71st Legislature by the Joint Study Committee on Treatment of Child Abuse. Austin, Texas.

Tex. S. B. 298. 1987. 70th Leg., Reg. Sess.

Tuma, June. 1989. "Mental Health Services for Children." American Psychologist, vol. 44, no. 2 (February).

Chapter 12. Services in Austin and Travis County

In order to obtain a better understanding of both existing services for SED children and adolescents and impediments to adequate service provision for this population, a study of agencies in Travis County, Texas, serving SED youth was undertaken. Appropriate agencies were identified (See Appendix 12.1) and contacted by participants in the LBJ Policy Research Project. Interviews with agency personnel in both clinical and administrative positions were then requested. A standardized questionnaire (See Appendix 12.2) was developed to provide consistency in interviews across agencies. In the end information was obtained from a total of twelve agencies. Twenty personal interviews were conducted with staff members from these agencies. This chapter reports conclusions reached from the interviews and questionnaire data.

The data reported here are not representative or generalizable in that: 1) the sample represents only those agencies granting interviews and providing requested information; and 2) the variation both in population demographics and available services across Texas counties is not reflected in data from Travis County alone. However, this survey was not meant to be comprehensive, but rather to enhance and to solidify the larger findings of the Policy Research Project with a sample of illustrative data.

WORKING DEFINITION OF SED CHILDREN AND ADOLESCENTS

In order to clearly specify the target population under study and to determine the extent of variation and confusion in defining parameters for identifying SED children and adolescents, our study utilized the following definition of SED children and adolescents:

Severely emotionally disturbed children typically suffer from severe emotional impairment affecting their ability to function on an appropriate developmental level in home, school and community environments. These children often manifest such symptoms as psychosis, suicide potential, poor self-esteem, risk for violence to persons and property, etc. Also, such children are often at risk of, or suffering from, separation from their family due to their emotional problems and/or chronic family dysfunctional status.

The present data show generally strong agreement with the theoretical working definition proposed. Only one agency utilized a more restrictive definition of "psychosis" as a criterion for defining children as SED. Most survey respondents, however, felt that the above definition needed to be expanded to specify and include those severe, negative situational elements (such as the child's family situation, dangerous environmental conditions etc.) that can put children in need of intensive mental health intervention.

Unlike the other agencies surveyed who have more freedom to employ a working definition of SED children and adolescents, the school systems' identification of SED children and adolescents is tied to the "handicapping conditions" criteria related to qualification for special education under PL 94-142 (See Chapter 2). According to school personnel interviewed, the majority of SED children and adolescents receiving services from the schools qualify as having an "emotional disturbance" according to handicapping conditions criteria. School personnel indicated that these criteria may be too restrictive. Children who are coping with severe, negative environmental conditions or who are manifesting symptoms of social maladjustment are, at present, excluded from mental health and related services under Special Education provisions. Also, another aspect of the criteria that may be too restrictive is that having an emotional disturbance is not enough, by itself, to qualify a child for special education--the disturbance must also be interfering with the child's ability to learn.

PROGRAMMATIC UTILIZATION OF THE SED DEFINITION

Whereas respondents can generally agree on a working definition of SED children and adolescents and, in fact, favor a more broadly defined one than that of PL 94-142, there appears to be much inconsistency and disagreement when definitions are used to define program eligibility and to designate funding responsibility. It is clear from the present study that the existing service delivery system is not organized around a consistent SED definition. This is apparent from the record-keeping approach adopted by the agencies in the interview sample. With the exception of three public agencies who show some evidence of organizing services around some sort of SED definition, no organization can handily identify the total number of SED youth served in the past year. These three exceptions are the local school district, the county Child Protective Services, and Austin State Hospital. The school district, based on PL 94-142 requirements, identified 1,420 children (out of a total enrollment of 69,580) as emotionally disturbed. This 2 percent figure diagnosed as emotionally disturbed is well below the national estimate of SED children and adolescents. The discrepancy may be attributed, at least partially, to the restrictiveness of PL 94-142 described in the previous section. At the same time it compares quite favorably with rates of identification by school districts in the state as a whole.

The second agency that was able to identify the number of SED children and adolescents served was Child Protective Services. This is because the information system in CPS groups children served according to the level of care the children are assigned to (See Chapter 3), and levels of care four to six correspond closely with our conception of SED children and adolescents. According to this reasoning, a total of 50 children placed in out-of home care under CPS auspices could be identified as SED. This is out of a total of 406 children who were placed last year in any level of care from one to six. Finally, there is probably little dispute that all youth served in the children and adolescents wards of the state hospital could be considered SED, and the Austin State Hospital served 268 of them over the course of last year. However, since the catchment area of Austin State Hospital extends beyond Travis County, it was estimated that only between 30 percent and 40 percent of the 268 cases were from within the county.

Among these public agencies, then, around two thousand cases of SED children and adolescents were served in 1989. However, it should be noted that there may be considerable overlap among the cases served by these agencies. For example, it would not be surprising if most of the youth served at Austin State Hospital had previously been identified as clients by special education or by Child Protective Services.

Among the other agencies in the study sample, there was little consensus--sometimes between two staff members of the same agency--on what proportion of the caseload could be considered SED youth. By not utilizing a consistent definition of SED children and adolescents, agencies have no definitive data on the numbers of these children being served, which leads to problems with program planning, staff deployment, financing services, etc.--not only on the local, but also on the national, level as well.

In addition to the problem of not being able to identify the number of SED children and adolescents needing and receiving services, lack of a consistently applied definition may also lead to adoption of less than adequate criteria. For example, since schools are the single agency with which children are mandated to have contact, and as will be shown later, with which most other agencies have some contact, it is reasonable to assume that other agencies might request school data and rely on the information obtained for assessment, placement, or treatment purposes. To the extent that the criteria used by schools underemphasize situational sources of disturbance, social maladjustment, or dysfunctional behavior not related to classroom learning, one might speculate that these factors also tend to be overlooked in other parts of the service system that rely on school information.

It would be important for future research to explore whether the criteria delineated by schools defining emotional disturbance are also influencing decisions other agencies might make regarding identification of SED children and adolescents and their need of and eligibility for services.

PROFILES OF SED CHILDREN AND ADOLESCENTS AND THEIR FAMILIES

Agencies were also asked to give a typical behavioral profile of SED children and adolescents and their families. SED children and adolescents were typically described as being depressed and aggressive (often alternating between withdrawal and acting out behavior), as having poor self esteem and poor judgment, and as lacking insight into the nature of their feelings. They were further characterized as having suffered multiple and severe childhood losses (due to instability of caretakers and environmental conditions) and as craving love and attention from authority figures. SED children and adolescents were also described as either not attending, or not performing well at school, and as often engaging in substance abuse and delinquent behavior. The majority of agencies estimated that between 50 percent to 100 percent of SED children and adolescents seen by them had also suffered from physical or sexual abuse and/or neglect.

The major diagnoses agencies assigned SED children and adolescents (in order of frequency) were that of Major Depression, Dysthymia, Conduct Disorder, Attention Deficit Disorder, Substance Abuse, Borderline Personality Disorder, and Post Traumatic Stress Disorder.

The families of SED children and adolescents were characterized as typically consisting of single parents (mostly single mothers), of low socioeconomic status (SES), who were isolated from the community and lacking in parenting skills. Agencies reported that family histories reflected cross generational cycles of poverty, disrupted families, physical and sexual abuse, substance abuse and criminal activity. Families were also described as having poor social relationships, judgment, and impulse control. Families were frequently described as having problems with role definitions and reality testing whereby children would often function as caretakers for parents and see their chaotic situations as normal.

Because of the general lack of distinction between the SED caseload and the other, less severe cases served by most agencies, demographic data specifically on SED youth was difficult to obtain. The following data pertains to the general youth population served by the agencies surveyed:

According to respondents' estimates, the gender breakdown of the young people served is quite even in the special education and child protective service systems. In most other agencies, there is a tendency for males to be slightly overrepresented. The most extreme imbalance is among cases going through the local juvenile court system, which is about four-fifths male.

The county juvenile court system also leads all agencies in ethnic imbalance. In Travis County about one quarter of those served are Anglo, about one-third Black, and over two-fifths Hispanic. These figures compare to the county-wide ethnic breakdown, among youth 18 years of age and younger, of 57 percent Anglo, 14 percent Black, 27 percent Hispanic and 2 percent other.[1] Thus, minority youth are over-represented in the juvenile court system. On the other hand, non-governmental treatment settings emphasizing clinical symptoms of disturbance, including nonprofit agencies providing psychological services to families and for-profit psychiatric treatment facilities, serve disproportionately Anglo youth. The ethnic compositions of the Austin State Hospital child protective caseload deviate only slightly from that of the general youth population, with Anglos slightly over-represented in the State Hospital and slightly under-represented among protective caseload. Finally, in the special education system itself, Hispanics are significantly under-represented--by about one-half--among those labeled emotionally disturbed.

AVAILABLE SERVICES AND PROGRAMS

A list of CASSP-defined treatments and services was included in the agency questionnaire and respondents were asked to delineate both those services which were currently available through their agencies and those that were needed but unavailable. The following table contains agency responses:

Table 12.1. Number of Agencies Providing CASSP-Defined Services and the Number Needing Services that are Unavailable

CASSP-Defined Service	Number of Agencies Providing Service	Number of Agencies Stating Service Needed but Unavailable
Psychiatric	10	2
Psychological	9	2
Social Work	11	
Case Management	11	
Family Therapy	9	1
Group Therapy	11	
Day School	7	3
In Home Services	7	5
Substance Abuse Treatment	7	
Residential Placement	8	1
Crisis Shelter	6	3
Therapeutic Foster Care	4	4
Respite Care	6	5
Hospitalization	9	2
Group Home	6	3
Parent Support	13	
Parent Education	12	
Referral	11	
Therapeutic Camp	7	1
Medication	7	2
Psychological Testing	11	
Physical Exam	10	

---

[1] Figures used by Texas State Population Estimates and Projection Program. This breakdown is based on 1970 and 1980 Census figures adjusted for projected migration patterns.

As can be seen from the above table, services offered by the fewest agencies and perceived as most needed but unavailable, are in-home services, therapeutic foster care, respite care, day schools, group homes and crisis shelters. Consistent with reports from the general literature, these so called "middle-range" services aimed at keeping children from more restrictive care and in their home communities, are those services most often lacking due to traditional patterns of treatment and funding in public agencies.

In addition to the lack of both funding and incentives to experiment with more innovative types of service provision, agencies also cited lack of skilled personnel to deal with these multi-problem children as another impediment to establishing needed services. Several agencies further commented that some services stipulated as needed but unavailable already existed in the community, but they were not available to families without financial resources or those needing sliding scale fees.

Some agencies added to the list of CASSP-defined services other treatments and services provided by their organization and considered important in the treatment of SED children and adolescents. These services included sexual abuse treatment, after school programs, independent living skills programs, GED training, programs like R.O.P.E.S. and Challenge Courses, sexual education counseling, and treatment for sex offenders.

Programs for SED Children and Adolescents

Having examined the range of services available, we thought it might be helpful to inquire about how the services are organized into programs. This is important because in the CASSP system, emphasis is placed on how the services are actually structured and coordinated. Among the public service delivery systems, the schools, child protective services, and the juvenile court each provide a limited number of programs for children in their system who have emotional problems. The Austin Independent School District offers a range of services for dealing with emotionally disturbed children, the least restrictive of which utilizes resource teachers and the most restrictive of which involves actual self-contained campuses for SED children at Dill Elementary and Rio Grande Secondary Schools. Additionally, the school system operates a visiting teachers program encompassing in-home and other social services. The Travis County Child Protective Service operates a therapeutic foster care program, and the Travis County Juvenile Court System operates a sex offender program as well as an after school program. All three agencies, moreover, rely heavily on contractual services from external providers for a range of services, from psychiatric evaluation and counseling to residential placements.

As the local agencies in the mental health system, Austin State Hospital and the Travis County Mental Health and Mental Retardation Center provide the most comprehensive range of services. However, in an official brochure describing all the service programs available, Travis County MHMR Center lists 26 mental health programs, but only seven of them involve children and adolescents, and only three of those seven have youth as a primary focus. These three programs are the Austin Center with limited respite care, Dayglo Family Treatment Program which serves those age 3 to 18 with abuse experience or other severe family problems, and Children's Liaison Unit which is primarily responsible for coordination and case management service with Austin State Hospital and Waco Center for Youth. Other services at the MHMR Center for which children are eligible include case management program, family support unit, hotline telephone counseling service, and the outpatient clinics operated at three different locations in Austin.

A few of the nongovernmental agencies dealing with SED youth are established for a specific range of problems. Naturally they offer limited and highly specific programs. Others, however, operate a wide array of programs. There seems to be a tendency among these agencies to emphasize programs dealing with sexual abuse and problems of addiction. Many of the services are organized as group programs in which past experiences are shared and coping skills are taught. Many of these agencies also emphasize education, GED, and general life skills.

Program Features

In addition to surveying the range of services and types of special programs offered by agencies, the present study was interested in the parameters of treatment within programs for SED children and adolescents. This section discusses data pertaining to both staff and program features. Respondents were asked to comment on duration, monitoring, completion, and follow-up of services within their agencies.

Regarding monitoring clients for progress during treatment, all agencies reported that some form of review process occurred. There was quite a span of time intervals over which progress or treatment plans were reviewed, ranging from daily to yearly checks. On average, most agencies reviewed clients for treatment progress between one-month to six-month intervals. Agencies did not report on the type or depth of the monitoring process, so the adequacy of treatment checks cannot be determined. It is significant, however, that all agencies have built in some mechanism to monitor client progress.

Responses to the question of whether or not clients typically complete treatment produced a distinctive pattern: In general, clients in treatment programs which had some type of legal mandate and authority over treatment, understandably, stayed in treatment until its completion. Other treatment programs reported drop-out rates ranging from 30 percent to 60 percent.

Schools reported that those students who enter Special Education programs mainly stay within the Special Education system, with some transitioning to higher or lower levels within the system. It will be important for future research to determine which factors (child or system related) serve to keep students in the Special Education system, with little movement back to regular classrooms.

Most agencies reported that very little follow-up was done on SED children and adolescents once treatment was either interrupted or terminated. Agencies stated that their primary means of follow-up were: out-patient appointments with other community agencies to follow up with the client, phone calls to other agencies that might further assist the client, or contacting clients by letter or phone call if appointments are not kept. Some variation in this pattern occurred, however, with one agency reporting having a full time discharge coordinator who sends periodic follow-up forms to clients and families for up to one year post-treatment. Two additional agencies reported informal meetings or ongoing phone calls with former clients. Although agencies recognized the need for follow-up services, most cited lack of funds as a major impediment to this service happening. When questioned as to whether clients return again to the agency once treatment has been interrupted or terminated, most agencies reported a return rate of between 10 percent and 40 percent.

All agencies reported that they recognized the importance of doing psychological testing for SED youth. The agencies either performed testing themselves or recommended it be done under contract for them. All agencies also reported using standardized instruments in the assessment process.

CHARACTERISTICS OF AGENCY PERSONNEL

The present survey was also interested in ascertaining the qualifications of staff serving the SED population. In most agencies, trained professionals held the majority of staff positions. Agencies utilized some students and trainees as well as on-job training, but in most cases, these represented only about one-fourth of the entire staff. There was quite a bit of variation in client staff ratios (ranging from 1:1 to 1:25) depending on the nature of the program and intensity of services offered. Most programs reported a client/staff ratio of about 1:8.

When agencies were questioned as to how their staff might be better utilized to serve SED children and adolescents, most agencies reported the need for existing staff to have more specialized training in caring for the needs of SED children and adolescents and their families. They also felt the needs of SED children and adolescents were so complex and demanding that staff would be more effective if they had lower caseloads and could concentrate more effort on coordination of services with other agencies and on case management services. Respondents also reported the need to experiment with more innovative treatment methods in serving this population--especially in providing a wider range of community and home-based services to the children on an out-patient basis.

INTERAGENCY RELATIONSHIPS

In addition to profiling SED children and adolescents and their families and obtaining information about the nature and quality of existing services for them, the present research also surveyed referral networks for SED children and adolescents and the nature of relationships between agencies serving this population.

In terms of frequency, parents, private providers, and TDMHMR were most often cited as referral sources across all the agencies. Referrals from schools, TDHS, police, and self-referrals were also identified as common ways that SED children and adolescents gain access to services. The fact that parents were cited as common referral sources for most agencies underscores the importance of expanding the CASSP initiative of involving parents as advocates and partners in the treatment plans for SED children and adolescents. It would be important for future research to determine the extent to which parents participate in the planning and treatment process of children once referrals are made.

The agencies surveyed reported a significant amount of contact with child advocacy groups. Ten out of twelve agencies had contact with at least one advocacy group, with four agencies reporting contact with multiple groups. The advocacy groups cited included Advocacy Inc., CASA, Parent Connection, Austin Families, Texas Association for Licensed Children's Services, Texas Network for Children, and Texas Association of Children's Treatment.

In addition to describing their association with advocacy groups, agencies were also asked to indicate those organizations with whom they coordinate services. Several respondents noted that "having contact with" rather than "coordinating services with" was a more apt description of the relationship between agencies. Since the present survey did not explore the type of interaction between agencies, the precise picture of these relationships is not clear. However, there does appear to be a wide range of linkages. On the one hand, a few agencies reported that caseloads are kept in separate agencies, with attempts to push children into total service by one agency or another, and on the other hand, some reported daily contact with other agencies. All agencies reported some contact with private providers and/or other public agencies or organizations serving SED children and adolescents. In most cases, this contact included at least two of the four major agencies (TDMHMR, TDHS, TJPC and the Schools) serving this population. Schools were the most frequently named organization with which other agencies have contact. In general, the data suggest more intensive interaction among smaller organizations and groups that serve SED children and adolescents and less interaction among the larger, state wide agencies. Given the heavy emphasis which the CASSP initiative gives to providing a range of community-based services and interagency coordination of those services, it will be important for future work to examine the ways and extent to which agencies jointly serve SED children and adolescents, as well as the incentives for, and impediments to, interagency coordination of service delivery.

CONCLUSION

This chapter has provided an impressionistic look at some of the service providers in Travis County. No claim is made that this is a complete picture, but all the major local public agencies are covered, as are some representative nongovernmental groups.

It seems that all types of treatment services for SED youth, as prescribed by the CASSP system, are available in Travis County, although the quantity of services available is not necessarily ideal. This is especially true for intermediate range services like crisis shelter, respite care, and therapeutic foster care. One also gets the impression that there are communications among service providers but there is less evidence of active coordination. If the local service delivery network is to be seen as a coordinated system, it would seem that the school district would be a natural starting point for that effort. Yet, the educational system is driven by a legislative criterion for SED that virtually all practitioners interviewed at the other agencies believe to be too restrictive. As we turn our attention from local service to statewide policy, we must not lose sight of this built-in discrepancy in the system.

Finally, one must wonder what the local service system may be like in other communities in Texas. Travis County, being the seat of state government and a center for social work and psychological education, is believed to have perhaps the most services available. The picture gathered in this chapter, then, should be considered an upper bound of what local service networks look like in Texas.

Appendix 12.1. List of Travis County Agencies Interviewed

Austin Independent School District, Special Education Division
Austin-Travis County Child Protective Services (Texas Department of Human Services)
Austin State Hospital Adolescent Unit and Child Psychiatric Unit
Travis County Mental Health and Mental Retardation Center
Early Childhood Intervention Council
Travis County Juvenile Court
Austin Child Guidance Center
CASA (Court Appointed Special Advocate)
Settlement Home
Middle Earth
Pebble Project
The Oaks Treatment Center (Brown Schools)

Appendix 12.2.

LBJ School of Public Affairs - Policy Research Project

Financing & Coordinating Care for Severely Emotionally Disturbed Youth

Austin-Travis County Agency Survey

According to our definition, severely emotionally disturbed children would fit the following criteria:

> Severely emotionally disturbed children typically suffer from severe emotional impairment affecting their ability to function on an appropriate developmental level in home, school and community environments. These children often manifest such symptoms as psychosis, suicide potential, risk for violence to persons and property, etc. Also, such children are often at risk of or suffering from separation from family of orgin due to their emotional problems and/or chronic family dysfunctional status.

We are interested in studying youth age 18 and under.

1. In your agency do you concur with this definition, or do you have alternative criteria?

____

____

____

____

****

Agency ________________________________

Respondent ____________________

Respondent position __________________

Interviewer ____________________

Interview date ___________________

Demographics

2. What was the total number of youth you served in 1989? ____________________

What about the number of SED youth you served in 1989? ____________________

2a. Ethnicity

What was the ethnic breakdown of all youth?

What was the ethnic breakdown of SED youth?

	Number	%	Number	%
Anglo				
Black				
Hispanic				
Asian				
Others				

2b. Age

What was the age breakdown of all youth?

What was the age breakdown of SED youth?

	Number	%	Number	%
0-5 years				
5-12 years				
13-14 years				
15-18 years				

2c. Gender

What was the gender breakdown of all youth?

What was the gender breakdown of SED youth?

	Number	%	Number	%
male				
female				

2d. Socioeconomic status

What was the socio-economic status breakdown of all youth?

What was the socio-economic status breakdown of SED youth?

	Number	%	Number	%
$30,000/yr or more				
$10-30,000/yr				
$10,000/yr or less				

2e. **Living arrangement**

What is the breakdown of living arrangements of all youth served?

What was the breakdown of living arrangements of the SED youth?

	Number	%	Number	%
both parents	____	____	____	____
mother alone	____	____	____	____
father alone	____	____	____	____
other relatives	____	____	____	____
adoptive parents	____	____	____	____
foster parents	____	____	____	____
in residential care	____	____		

2f. **Duration of service**

Typically, how long were the youth in treatment in your agency?

Typically, how long were SED youth in treatment in your agency?

	Number	%	Number	%
0-3 mo.	____	____	____	____
3-6 mo.	____	____	____	____
6-12 mo.	____	____	____	____
more than 1 year	____	____	____	____

2g. **Residency**

How many youth served lived...

How many SED served lived...

	Number	%	Number	%
in Travis Co.	____	____	____	____
out of Travis Co.	____	____	____	____
out of State	____	____	____	____

Diagnosis

3. Do you typically do psychological testing on your youth? Yes________ No________

If yes, what type of professional does this assessment?

____

4. Do you utilize standardized diagnostic criteria in assessing the youth your agency serves? (e.g.: DSM-III-R?; ICD-CM; Achenbach Rating Scales)

yes________ no________

If yes, which criteria are used? ____________________________

____

5. What are the diagnoses most frequently given to youth served by your agency?

____

____

6. What, if any, is a typical behavioral profile of SED youth served?

____

____

7. What, if any, is a typical family profile of severely emotionally disturbed youth you served?

____

____

8. Client past experiences

	What percentage of your youth clients would you estimate are...		What percentage of your SED youth clients would you estimate are...	
	Number	%	Number	%
physically abused and/or neglected	____	____	____	____
sexually abused	____	____	____	____
substance abuser	____	____	____	____
diagnosed as having behavior problems	____	____	____	____
in the Juvenile Justice System	____	____	____	____

Services/Treatment

9. Are clients monitored for progress during treatment? yes____ No____

If yes, how often? ____

10. What type(s) of treatment does your agency provide for severely disturbed youth? And which treatments do you perceive as needed but unavailable?

	Provided	Unavailable
Psychiatric	______	______
Psychological	______	______
Casework	______	______
Case Management	______	______
Family Therapy	______	______
Day School	______	______
Intensive Family Services	______	______
Drug Treatment	______	______
Crisis Residential Placement	______	______
Therapeutic Foster Care	______	______
Respite Care	______	______
Hospitalization	______	______
Group Home	______	______
Parent Support	______	______
Referral	______	______
Therapeutic Camp	______	______
Pshchotropic drug treatment	______	______
Pshchological testing	______	______
Routine Physical	______	______
Others (Please specify)		
________________	______	______
________________	______	______
________________	______	______
________________	______	______

11. In your judgment, why are these services unavailable?

____

____

12. Typically, in serving severely emotionally disturbed youth, what types of interagency coordination takes place?

TDMHMR ______
TDHS ______
Law enforcement ______
Juvenile probation ______
TYC ______
Public housing ______
Food stamp ______
School ______
Others ____

13. In providing services for severely emotionally disturbed youth, is your agency involved with

	Yes	No
Advocacy Groups		
Other Agencies		

Please specify ______________________________

____

14. Who typically refers severely emotionally disturbed youth to your agency?

	Number	%
parents/family		
school		
self referral		
TDHS		
law enforcement		
TYC		
TJPC		
private care providers		
others (Please specify)		

15. Typically do severely emotionally disturbed youth treated by your agency...

	Yes	No
Complete proposed treatment plan?		
End therapy prematurely?		
Return to agency for further treatment after termination		

16. What kind of mechanisms, if any, does your agency have for following up severely emotionally disturbed youth? ______________________________

____

Funding

17. What was your 1989 budget?________________________________

18. What was the amount allocated in 1989 to

adult services $________

youth services $________
severely disturbed youth services $________

19. What funding sources does your agency utilize?

	% of funding	Please specify program
Federal funding	______	______________________________
State funding	______	______________________________
County fundin	______	______________________________
United Way	______	______________________________
Out-of-pocket charges	______	____________________________
Private insurance	______	______________________________
CHAMPUS	______	______________________________

Others, specify________________________________

21. Are there Federal Funds available to your agency which you currently are not receiving?

____

____

Program

22. What particular programs within your agency serve severely emotionally disturbed youth?

____

____

23. How could your staff be better utilized to serve severely emotionally disturbed youth?

____

____

24. What is your typical ratio between care providers and clients?________________ ___

25. What is the training background of your staff? (Number or percentage)

____ Professional degree or certificate
____ Other degrees (____________________)
____ On-site training
____ Other ____

26. How about those working on severely emotionally disturbed youth trained?

____ Professional degree or certificate

____ Other degrees (____________________)
____ On-site training
____ Other ____

27. Do you have any comments/concerns, etc. about treating severely emotionally disturbed youth that we have not so far covered?

____

____

____

Chapter 13. Expansion of Medicaid to Cover Services for Severely Emotionally Disturbed Children and Adolescents in Texas

PREFACE

The federal government plays a major role in financing health care services through Medicare and partial funding of Medicaid. It has also played a leadership role in the development of health care payment systems. Medicaid is a key component of financing care for many severely emotionally disturbed children and adolescents in a number of states. Traditionally, coverage for mental health services has been less extensive than coverage for other medical services (U.S. Congress, OTA, 1986, p. 135).

In FY 1985 Medicaid represented 55 percent of all public health funds spent on children nationwide (U.S. Congress, House of Representatives, Select Committee on Children, Youth, and Families, 1985). With a number of changes, Medicaid has developed the capacity to cover many more SED children and adolescents for a broader variety of services. This program has the potential to help states meet the needs of children who are at the greatest risk for developing mental disorders: those who are in poverty and those who are uninsured (U.S. Congress, OTA, 1986, p. 136). Texas has been slow in taking advantage of Medicaid and of recent changes in Medicaid regulations. With careful planning, Texas can develop a cost-effective State Medicaid Plan which would bring in many more federal dollars for youth services.

Many states have been using their Medicaid system to help finance mental health services for children and adolescents. Texas has been reluctant to use this financing mechanism because of the potential for significantly increased costs to the state. It is becoming clear that this has been a very short-sighted policy since the state ends up paying for the care of emotionally disturbed children through the public mental health system, the school system, and through the juvenile and adult justice systems with mostly state monies. However, with increased pressure to ameliorate the problems of SED children and adolescents new funding mechanisms need to be examined.

Increased pressure is also coming from the federal government for the states to better serve this population. Recent Medicaid legislation may force Texas and all other states to expand all services to low-income children.

This chapter looks at how current Medicaid regulations can be used by Texas to expand reimbursable services to SED children and adolescents. A brief overview of Medicaid and its involvement in mental health services is followed by a discussion of the eligibility requirements for the program. The third section examines the mandatory and optional services offered through the Medicaid program as well as the ways in which Texas is expanding and can expand services to children and adolescents, with particular attention to recent significant changes to Medicaid regulations. The experiences of other states in their attempts to use mandatory and optional services to best suit the mental health needs of the youth in their population will also be examined. The chapter will end with a discussion of the role Medicaid might play establishing school-based mental health services.

OVERVIEW OF MEDICAID

Medicaid, authorized under Title XIX of the Social Security Act, is a federally aided, state-administered medical assistance program for low-income people. Generally, those receiving cash assistance under Aid to Families with Dependent Children (AFDC) or Supplemental Security Income (SSI) programs are mandatorily eligible for Medicaid assistance. Additionally, each state has the option of providing Medicaid benefits to certain persons who cannot afford needed health care, but have income above the maximum allowable for public assistance.

Each state is allowed to set provider and dollar limitations on the amount, duration, and scope of Medicaid coverage. Each state also has the option of covering certain mental health services. As a result, each state has considerable flexibility in establishing the nature and extent of mental health services available to Medicaid recipients.

The U.S. Department of Health and Human Services (USDHHS) has overall responsibility at the federal level for administering Medicaid. Within USDHHS, the Health Care Financing Administration (HCFA) is responsible for developing program policies, setting standards, and ensuring compliance with federal Medicaid legislation and regulations. The Texas Department of Human Services (TDHS) is the single state agency responsible for determining recipient eligibility and for proposing the amount, duration, and scope of benefits. The administration of the program is accomplished through a variety of arrangements with medical professionals; National Heritage Insurance Company (NHIC), the health insuring contractor; and state agencies such as the Texas Rehabilitation Commission, the Texas Department of Health, and the Texas Department of Mental Health and Mental Retardation (TDMHMR). Providers of Medicaid-eligible services can be reimbursed for their services through direct payment from either NHIC, or through direct vendor payments by TDHS (TDHS, 1989a, p. 1).

The expense of Medicaid is shared by federal and state government. Depending on a state's per capita income, the federal match of a state's total Medicaid costs for health services in FY 1987 ranged from 50 to 78.5 percent. In Texas the federal portion of the match in 1990 was 61.23 percent (Koyanagi, 1988, p. 102). Because of Texas' declining relative income, it is estimated that the federal match will be close to 65 percent by 1991 (McCormack, 1989, p. 3). The federal government also assumes 75 percent of the cost of administering the program (Vischi, June 1988, p. 104).

Medicaid and Mental Health Services

Medicaid reimbursement of mental health services is available through a variety of mandatory and optional services financed under Title XIX of the Social Security Act. Title XIX, however, specifically excludes the care of the mentally ill aged 22 to 64 in institutions for mental diseases (IMDs).* Each state has the option of providing Medicaid coverage for institutional care of the mentally ill who are under 22 or over 64 years of age. At this time Texas does not use these options.

Several states have been very aggressive in their pursuit of Medicaid funds to pay for mental health services. In many instances, these states are aided by a strong and growing economy, a sympathetic legislature, or an organizational structure (i.e., the location of the state mental health agency within a general state human services department) that predisposes the state toward including mental health services in the State Medicaid Plan. However, for many states it is a matter of knowing what is available and having a state mental health agency that is dynamic (or desperate) enough to go after these funds.

The National Mental Health Association has identified the Medicaid outpatient and inpatient options contained in each states' plan. Table 13.1 shows the Medicaid outpatient options by state.

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* IMDs are defined as institutions in which more than 50 percent of the inpatient population have a primary diagnosis of mental illness.

Table 13.1. Medicaid Mental Health Outpatient Options by State

			Clinic		Hospital								
State	Case Mgmt	Rehab	Out-Patient Therapy	Partial Hospitalization	Gen Hosp Day Treat	Psych Hosp: Outpatient	Limits on Psych Services	Psychologist Services	Social Worker Services	EPSDT Expended Services	MH Personal Care	MH Home Health Care	Home & Community Based Waiver
Alabama										X			
Alaska					X								
Arizona													
Arkansas		X	X	X	X					X			
California			X	X		X	X	X					X
Colorado	X		X	X	X	X		X	X		X	X	X
Connecticut				X	X	X	X	X	X	X		X	
Delaware			X	X						X			
D.C.			X		X	X		X		X	X	X	
Florida		X	X			X					X		
Georgia	X		X	X	X			X				X	
Hawaii			X					X		X			
Idaho		X	X				X	X					
Illinois			X	X	X			X	X				
Indiana			X			X	X	X				X	
Iowa			X					X	X			X	
Kansas			X	X			X	X		X	X	X	
Kentucky			X	X			X	X	X	X	X	X	
Louisiana			X	X	X							X	
Maine		X			X	X		X	X		X	X	
Maryland			X	X	X	X	X			X	X	X	
Massachusetts			X	X	X	X		X	X				
Michigan			X	X	X	X					X		
Minnesota			X		X	X		X			X	X	
Mississippi			X		X		X						
Missouri			X	X		X							
Montana			X	X				X	X				
Nebraska			X	X		X							
Nevada			X	X				X					
New Hampshire	X	X	X	X			X	X					

(Continued Next Page)

Table 13.1 (Continued). Medicaid Mental Health Outpatient Options by State

			Clinic		Hospital								
State	Case Mgmt	Rehab	Out-Patient Therapy	Partial Hospitalization	Gen Hosp Day Treat	Psych Hosp: Outpatient	Limits on Psych Services	Psychologist Services	Social Worker Services	EPSDT Expanded Services	MH Personal Care	MH Home Health Care	Home & Community Based Waiver
New Jersey			X		X	X	X	X		X	X		
New Mexico			X					X					
New York		X	X	X	X	X		X		X	X	X	
North Carolina		X	X	X	X	X	X						
North Dakota			X	X	X	X						X	
Ohio	X	X	X	X	X	X	X	X				X	
Oklahoma			X	X	X	X	X	X					
Oregon		X	X		X	X			X				X
Pennsylvania			X	X	X	X				X			
Rhode Island	X	X			X	X					X	X	X
South Carolina	X	X	X	X		X				X	X		
South Dakota		X	X	X	X	X		X		X	X	X	
Tennessee			X	X		X	X			X			
Texas	X	Pending	-	-	-	-	X	X	-	-	-	-	-
Utah			X	X			X	X		X	X	X	
Vermont	X	X	X	X		X		X				X	X
Virginia			X				X	X	X	X		X	
Washington	X		X	X	X	X	X						
West Virginia	X		X	X		X	X				X		
Wisconsin		X	X			X		X	X	X			
Wyoming			X										

Source: Koyanagi, 1988, pp. 91-92

Every state in the union has a different mixture of services available. Under these services identified by the Mental Health Association, Texas only covers psychologists' services (under the supervision of an M.D.) and, drugs, but during the spring of 1990 targeted case management for the mentally ill, was added. The rehabilitation option was still pending. Texas provides fewer mental health services through Medicaid than any of the other ten most populous states.

Eligibility for Medicaid

Medicaid regulations allow for mandatory and optional categories of recipients to be eligible for services. As mentioned above, mandatory groups as of April 1990 include the "Categorically Needy," which comprises children in families receiving AFDC and those deemed eligible for SSI as well as pregnant women and children five and under when they fall below 133 percent of poverty. During FY 1988 approximately 25 million people were served by Medicaid. Of those, 94.4 percent fell into the "Categorically Needy" group. Figure 13.1 illustrates the national breakdown of Medicaid beneficiaries by eligibility status during FY 1988. As this figure shows, the largest number of beneficiaries of Medicaid are children, followed by their parents.

In Texas eligibility for children above five and non-pregnant women is currently restricted to one-parent families with income below 24 percent of the federal poverty level. This very low income cutoff excludes many poor people in Texas from Medicaid coverage (McCormack, 1989,pp. 26-27). Table 13.2 shows the income/benefit maximums by family size for families to be eligible for AFDC and the accompanying Medicaid benefits.

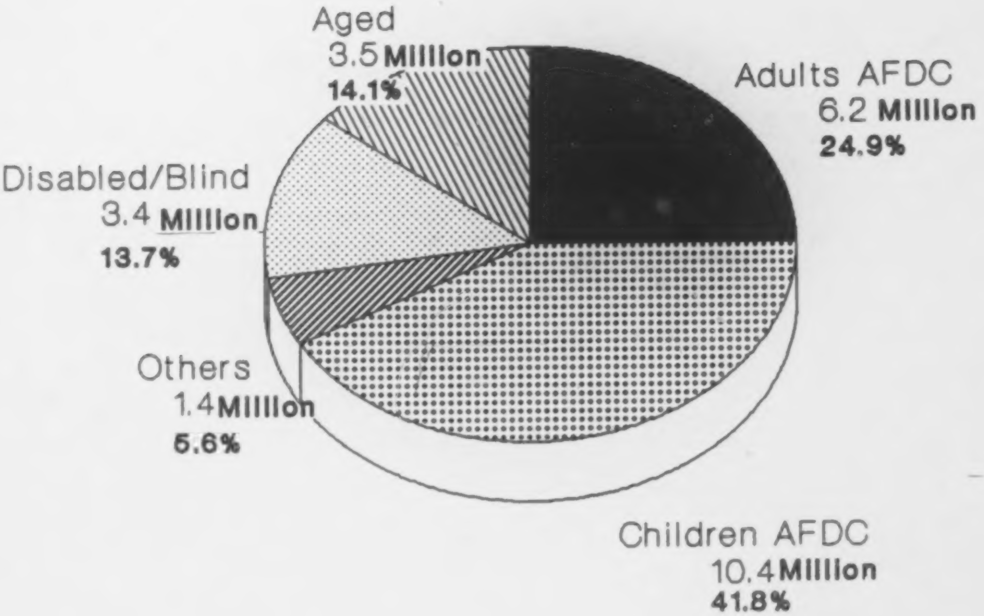
As can be seen by the Maximum Adjusted Net Income column, those eligible for this program have to be extremely destitute. Many working poor women and their children would not be eligible for Medicaid benefits through this avenue. The income of Supplemental Security Income recipients cannot exceed, after exclusions and deductions, current benefit levels of $4,248 per year ($354 per month) for an individual or $6,384 per couple ($532 per month). An additional $178 per month in extra income is allowed for each "essential" person living in the home (Vischi, June 1988 p. 77).

However, many states supplement the federal portion of the SSI payment. As of January of 1988, 27 states had some kind of state supplementation of SSI. This supplementation ranges from $2 per month in Oregon to $393 in Connecticut (U.S. Congress, CRS, 1988, pp. 289-290). Because the total amount of the benefit given to SSI recipients is increased, the maximum allowable income is also increased. Therefore, benefit and maximum allowable income levels vary significantly from state to state.

The third avenue of eligibility is through the optional "Medically Needy" program. This program allows states to extend benefits to categorically related children whose families are ineligible for cash assistance on the basis of income and resources, yet too poor to pay for medical care. States set Medically Needy income eligibility at an amount up to 133 1/3 percent of the AFDC payment level and permit others to participate if their medical expenses are high enough (Fox, 1987, p. 5). This allows families to "spend down" to the eligibility level. To become eligible, a family must expend all income and assets on the medical treatment of an family member.

Texas sets very strict income and resource limits to be eligible for the Medically Needy program. As shown in Table 13.3, a family of three would have to be making only $267 per month after deductions (such as for medical expenses) and have maximum available resources of only $1,000.

Figure 13.1. Medicaid Beneficiaries by Eligibility Status During FY 1988



Source: U.S. Congress, House of Representatives, Committeen on Energy and Commerce, Subcommittee on Health and the Environment, November 1988, p. 24.

Table 13.2. Maximum Adjusted Net Income Levels for AFDC Eligibility by Family Size

Family Size	Maximum Adjusted Net Income* (Equal to Maximum Grant Amount)
2	$ 158
3	$ 184
4	$ 221
5	$ 246
6	$ 284
7	$ 308
8	$ 351

Source: TDHS. 1988b.

* Adjusted Net Income is the amount of Earned Income minus work-related expenses; child care; and earned income disregard ($30 for the first 12 months plus one third of the remainder for the first 4 months. Unearned Income, such as Social Security, is completely subtracted from the Maximum Grant Amount.

Table 13.3. 1989 Texas Medically Needy Income and Resources Limits

Family Size	Monthly Income	Maximum Resources
1	$ 100	$ 1000
2	$ 211	$ 1000
3	$ 267	$ 1000
4	$ 301	$ 1000
5	$ 349	$ 1000
6	$ 385	$ 1000
7	$ 432	$ 1000
8	$ 468	$ 1000
9	$ 523	$ 1000
10	$ 560	$ 1000
11	$ 615	$ 1000
12	$ 651	$ 1000
13	$ 707	$ 1000
14	$ 743	$ 1000
15	$ 797	$ 1000

Source: TDHS, 1989a.

Note: For each additional person add $57 in income.

These very restrictive limits on income and resources exclude a large number of the working and nonworking poor in Texas. Figure 13.2 shows the various eligible groups and the percentage of the poverty level to which their income must correspond in order to be eligible.

The Omnibus Budget Reconciliation Act of 1986 included a second optional group in the Medicaid program. This option allowed states to provide coverage to young poor children who meet neither the categorical nor financial criteria for AFDC. States are authorized to extend eligibility to all pregnant women, infants up to age one, and, incrementally over five years, children up to age five whose family income does not exceed 100 percent of the federal poverty level. Children eligible under this category are entitled to the same benefit package available to regular cash assistance recipients (Fox, 1987, p. 19). However, this was changed by OBRA 89 which raised the family income to 133 percent of the federal poverty level for those with children five and under. The Family Support Act of 1988 requires states by FY 1991 to continue Medicaid coverage to persons who lose AFDC eligibility due to higher income. This section gives those families up to 12 months of additional Medicaid coverage as long as their income stays at or below 185 percent of the poverty line. This provision is to be mandatory sometime in 1990 (TRL, March 1989, p. 5).

EXPANDING MEDICAID TO COVER MENTAL HEALTH SERVICES

There are four ways that Medicaid can be expanded to cover more mental health services. The first is to more fully use portions of the current Medicaid plan. The second way is to use the various waivers that have been passed by Congress since 1981. The third way is to amend the State Medicaid Plan to cover services that are available, but optional, under current Medicaid regulations. The last way to expand coverage of Medicaid is for Texas to supplement SSI payments. By doing this, Medicaid eligibility would be extended to all those whose income is at or below the SSI eligibility level plus state supplement level. All or some of these alternatives could be used to help pay for the cost of mental health services in Texas.

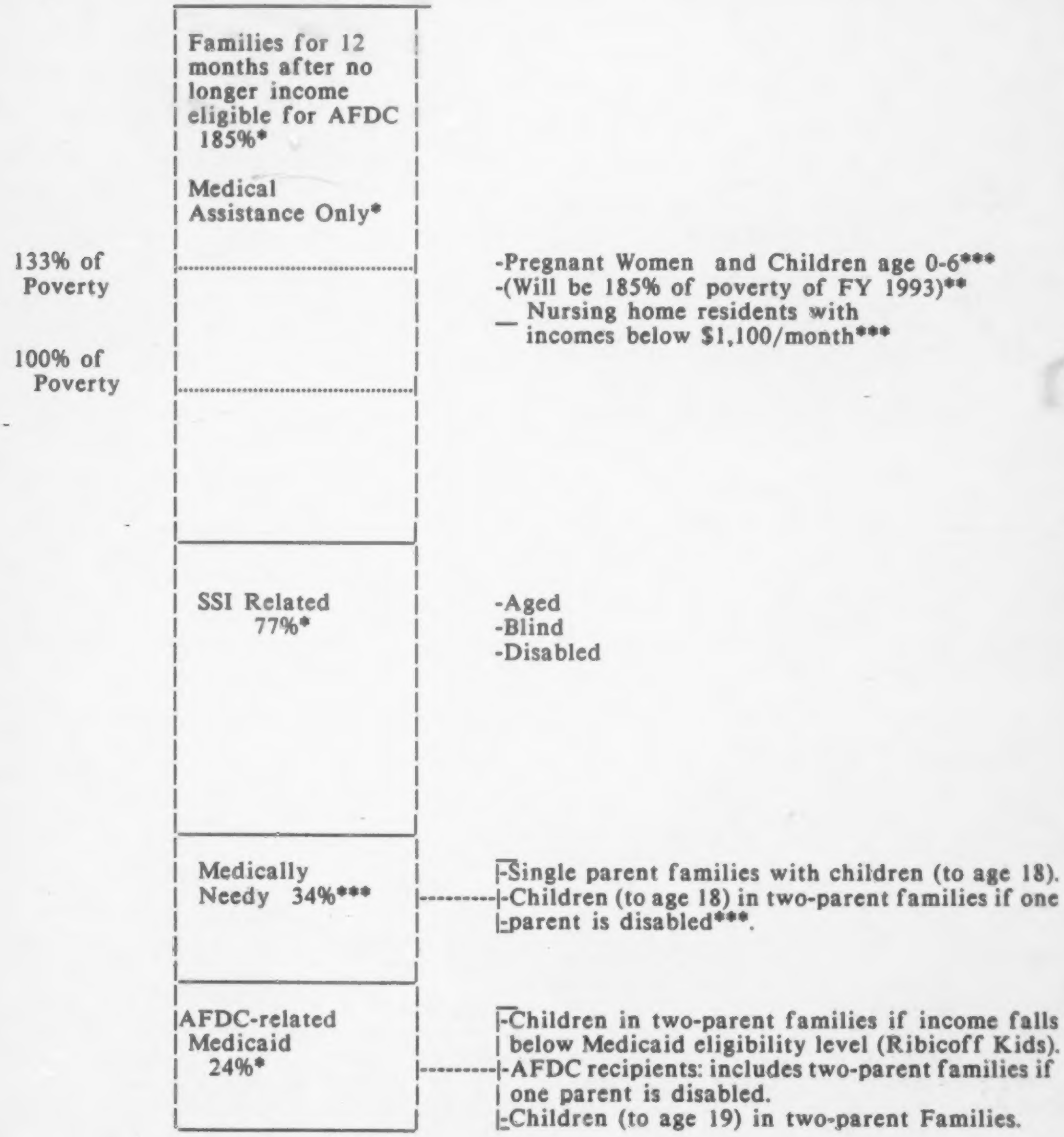
Texas is pursuing a strategy whereby it can expand services to mentally disabled citizens without additional expenditure of state funds. Because of the "Freedom of Choice" clauses in Title XIX, a state cannot limit Medicaid providers to those in the public sector. If a private provider meets the specifications set forth by the state to be a provider of a Medicaid-payable service, the state must match the federal payment for those services (Russell, Interview, May 18, 1989)

Texas provides many mental health services with 100 percent state and local appropriations. Table 13.4 lists mental health services identified as necessary components of care by CASSP. These services are matched to Medicaid services under which they could qualify for reimbursement.

Many of these services provided by Texas could be eligible for Medicaid reimbursement. Texas funds mental health services for children and adolescents with little or no aid from the federal government because the services are not included in the State Medicaid Plan or because the services provided exceed the limits of those offered. As a result, the state is not taking advantage of the 61 percent discount on certain mental health services that are already provided to the state's Medicaid-eligible mentally ill population.

By using the "soft-match" approach to federal fund participation, funds from the existing, fully funded state/local programs could be reallocated as matching funds for new Medicaid options. Most states using this approach have reallocated funds for services that are similar or identical to the new or expanded Medicaid services (NASMHPD, January 1987, p. 33). The problem that is often encountered in using local funds as part of the

Figure 13.2. Medicaid Coverage in Texas As of April 1, 1990


Families for 12 months after no longer income eligible for AFDC
185%*
Medical Assistance Only*
133% of Poverty
100% of Poverty
-Pregnant Women and Children age 0-6***
-(Will be 185% of poverty of FY 1993)**
Nursing home residents with incomes below $1,100/month***
SSI Related
77%*
-Aged
-Blind
-Disabled
Medically Needy 34%***
-Single parent families with children (to age 18).
-Children (to age 18) in two-parent families if one parent is disabled***.
AFDC-related Medicaid
24%*
-Children in two-parent families if income falls below Medicaid eligibility level (Ribicoff Kids).
-AFDC recipients: includes two-parent families if one parent is disabled.
-Children (to age 19) in two-parent Families.

*Sources: *TRL, March 1988; **"For the Record," 1989; ***TDHS, 1989a; ****U.S. Congress, December 1989.

Table 13.4. Comprehensive Service System Components and Relevant Medicaid Service(s)

Comprehensive Service System Components	Relevant Medicaid Service(s)
1. Case Management A set of services provided by a case manager which include identifying the needs of individual youngsters and assisting them to access services, advocating on their behalf, ensuring that an adequate treatment plan is developed and implemented, reviewing client progress and coordinating services.	Case Management Option Home- and Community-Based Waivers
2. Day Treatment Services A non-residential program of several hours duration, which includes both treatment and educational components.	Rehabilitation Services Home- and Community-Based Waivers Clinic Services Partial Hospitalization Services of a General or Psychiatric Hospital
3. Early Identification, Assessment and Intervention Services	Early [illegible]iodic Screening Diagnosis and Treatment (EPSDT)
4. Outpatient Assessment and Treatment Mental Health services including evaluation, diagnosis and treatment delivered either in a community facility or in the home (including home	Clinic Services Outpatient Hospital Services General Hospital Services Services of Psychologists and & Psychitric Social Workers. Prescribed Drugs Home Health Care Home & Com. Based Waivers
5. Emergency & Crisis Management Services Emergency Mental Health Services available 24 hours a day, seven days a week, delivered in either a community facility or in the home.	Clinic Services Rehabilitation Services General Hospital Services Physicians's Services Services of Psychologists and & Psychitric Social Workers Home Health Care
6. Alternative Family Living Specialized residential care provided in a community-based facility (e.g. therapeutic foster care, therapeutic residential group care, therapeutic camps, and independent living	Not a covered service, but some elements may be covered through Home Health Care, Personal Care Services, Rehabilitation, or Waivers.
7. Crisis residential hospital services Short-term inpatient hospital care available in General Hospital inpatient care.	Inpatient Psychiatric Hospital Care

Table 13.4 (continued). Comprehensive Service System Components and Relevant Medicaid Service(s)

Comprehensive Service System Components	Relevant Medicaid Service(s)
8. Intensive Care Services Services not necessarily available in every local community but required to be available within a reasonable time and/or distance to all children and adolescents with servere emotional disturbance. Intensive care services include inpatient hosptial treatment and/or treatment at residential treatment centers. Each child placed in such a facility will have an individual treatment plan. The facility may be secure.	Inpatient Psychiatric Hosipatal
9. Prevention Interventions directed at those not yet identified as having emotional problems, especially those children who by virtue of genetic of situational factors are at the highest risk of serious emotional disturbance.	EPSDT

Source: Koyanagi, 1988, pp. 35-36.

state's Medicaid match is determining which agency actually has control over the funds. Having local public funds serve a function that has traditionally been that of only state funds can become complicated.

Normally, reimbursement of Medicaid claims for physician and hospital services in Texas is handled through NHIC, which has an "insured" contract with TDHS whereby it receives a fixed premium for each enrolled Medicaid client as well as a number of fees. NHIC is partially at risk for additional costs in the event they exceed the estimated cost of the contract. Vendor drugs, nursing homes, and a number of other providers are outside the scope of the NHIC contract and are reimbursed by TDHS directly. The payments are made from state funds, and the federal government then pays for its share of the matching funds. With the "soft-match" approach, other state and local agencies that have been spending state and local public funds for potentially Medicaid-reimbursable services would be able to "certify" these state and local funds as the state Medicaid match. Other states have been using this approach with a great deal of success.

Because of the differences in state financing structures, different ways of using funds are required. In Texas, local tax revenues make up about 10 percent of the funding for CMHMRCs. The funds come mainly from cities and counties. Of the total financial assistance provided by local taxes, approximately one-half went from Harris County to the Mental Health and Mental Retardation Authority of Harris County. Another center, Lubbock Regional MHMR Center, received no local tax support in 1988. The remaining centers received approximately 6 percent of their total funding from local taxes (Jung, 1990). TDMHMR has allowed other types of local funds to be counted in computing the local match. These include but are not limited to private insurance reimbursements and reimbursements on state contracts for services rendered and federal ICF-MR, Medicaid, and Medicare (Jung, 1990). Table 13.5 shows that breakdown of what was called "local funds" by the CMHMRCs during FY 1989.

Of the $91 million counted as local funds during FY 1989, $20 million is immediately identifiable as monies of federal origin (Titles IV, XVIII, and XIX). Many of the funds received from other state agencies may also be of federal origin. For example, all of the $3.7 million received from the Texas Commission on Alcohol and Drug Abuse originates from the federal Alcohol, Drug Abuse, and Mental Health Block Grant.

Some limitations do apply to the use of other state agency and local funds as a state Medicaid match. For example, state funds must make up at least 40 percent of the total amount which is to be put up to be matched by federal funds (TRL, March 1989, p. 146). In the case of CMHMRCs in Texas, they would have to "donate" their funds received from TDMHMR and local sources to TDHS. This donation process can be done in several ways. First, there can be a direct donation to the state Medicaid agency; second, funds can be transferred to the state Medicaid agency from another public jurisdiction (such as a hospital district or another state agency); and, third, other agency and local funds can be "certified" by the state Medicaid agency as representing expenditures eligible for federal financial participation.

Under the last option there is no actual transfer of funds to the state Medicaid agency. For the funds to be certified as state Medicaid match, it has to be demonstrated that the funds being used to draw the federal match did not originate with the federal government. In this way local entities can certify that funds were spent on Medicaid-eligible persons and services and receive reimbursement of the federal portion of the match without ever losing actual control over the funds in their accounts. With a current federal matching level of 61 percent in Texas, the potential for increasing available services to Medicaid-eligible persons cannot be ignored. In 1987, TDMHMR estimated that up to $50 million could be generated for community mental health services using this approach (TDMHMR, 1987b, p. 11). The local providers of Medicaid would have to find who among

Table 13.5. Community MHMR Centers Local Funds During FY 1989

Origin	Amount
City Tax Funds	$ 2,270,411
County Tax Funds	22,998,042
Other Local Tax Funds	611,466
Patient Fees and Insurance	13,942,292
Miscellaneous Income & Contributions	21,610,821
Title XVIII - Medicare	523,581
Title XIX - Medicaid	851,652
Title XIX - ICF-MR	14,135,132
Board of Pardons & Paroles	6,865
Texas Commission of Alcohol & Drug Abuse	3,703,483
Texas Rehabilitation Commission	1,992,854
Texas Dept. of Highways & Public Transportaion	3,554,914
Title XIX - HCS-MR	3,724,391
Title IV-B	498,869
Other State & Federal Agencies	1,393,592
Total Local Funds	$ 91,818,365

Source: Roberts, 1990.

their clients are Medicaid-eligible and which of their services could become eligible for reimbursement.

MEDICAID EXPANSION AND SED CHILDREN AND ADOLESCENTS

Medicaid in Texas is available for treatment of mental diseases, but this coverage is extremely limited. The Texas State Medicaid Plan currently provides some mental health services through existing mandatory and optional services.

Mandatory Medicaid Services

Of the ten mandatory services which are reimbursable under Medicaid (Appendix 13.1), several can be used for services other than traditional medical treatment. Because states have broad latitude in setting the parameters of these mandatory services, mental health and other potentially reimbursable expenses are often not included. The four mandatory services which provide the greatest opportunities for expanded coverage in Texas are

1. Inpatient Hospital Services
2. Outpatient Hospital Services
3. Physicians' Services, and
4. Early and Periodic Screening, Diagnosis, and Treatment (EPSDT)

The next sections will consider in greater detail how Texas can more effectively use these mandatory services already in the State Medicaid Plan.

Inpatient Hospital Services. Services provided through the psychiatric units of general hospitals are eligible for Medicaid payment. Medicaid does cover those eligible with psychiatric diagnoses for acute and general care inpatient hospital services ordinarily furnished in an approved hospital. These services will include bed and board in semiprivate rooms (TDMHMR, 1985, p. 2). Reimbursement to hospitals for inpatient services is limited to the Texas Medicaid spell of illness, which is defined as "30 days of inpatient hospital care, which may accrue intermittently or consecutively." Once 30 days of inpatient care have been provided, reimbursement for additional inpatient care is not considered until the recipient has been out of an acute care facility for 60 consecutive days (TDHS, 1989a, p. 208). Reimbursement for inpatient services is limited to $200,000 per recipient per benefit year (TDHS, 1989a, p. 205). IMDs are specifically excluded by the Texas State Medicaid Plan.

Outpatient Hospital Services. These services are defined as "any preventive, diagnostic, therapeutic, rehabilitative, or palliative service furnished to an outpatient in a certified hospital facility by or under the supervision of a physician or dentist" (Fox, 1987, p. 25). These services can include inpatient psychiatric services, depending on the limits established by the state. Texas does reimburse for psychiatric outpatient services, but the reimbursement is limited. The Medicaid Provider Procedures Manual spells out that "Outpatient psychiatric services for the diagnosis or treatment of mental, psychoneurotic, or personality disorder are reimbursed at 62.5 percent of the Medicaid reasonable charge allowances for the procedures billed with a calendar year limitation of $312.50 per recipient unless prior authorization is obtained. The $312.50 limitation may be waived if the continued treatment is medically necessary and the treating physician has requested and obtained prior authorizations from NHICs's Medical Director. Prior authorization, though, is a condition of reimbursement and not a guarantee that any payment will be made" (TDHS, 1989a, p. 265).

Physicians' Services. These are services that can be furnished in an office, a patient's home, a nursing facility, or other setting. They are defined to include any service provided within the scope of practice of the profession or under the personal supervision of a licensed physician. For the most part, states have the same benefit policies for psychiatrists' services as for other physicians' services (Fox, 1987, p. 33). In Texas, however, the limits on psychiatrists' services are the same as for hospital outpatient psychiatric services. The $312 per year limitation on reimbursement is applicable whether it is billed under psysicians' and/or hospital outpatient services.

Early and Periodic Screening, Diagnosis, and Treatment Services (EPSDT). The EPSDT program is considered to be the most comprehensive federal prevention and treatment program for persons under the age of 21. The program was added to Medicaid in 1967 as a mandatory service. Recent changes to Medicaid, contained within the Omnibus Budget Reconciliation Act of 1989 (OBRA-89), have made potentially dramatic changes to this program. This section will examine the background of the EPSDT program, how it currently operates in Texas, and then changes which were made by OBRA-89. This program as currently structured will be the most important mandatory service for treating Medicaid-eligible SED children.

When EPSDT was added to Title XIX in 1967 it was to be made available to all Medicaid-eligible recipients [illegible] the age of 21 in order to "ascertain physical or mental defects and to provide treat[illegible] to correct or ameliorate defects or change conditions found" (CDF, January 1990, p. 3). The statute requires that all eligible persons be informed as to the availability of the EPSDT services and assisted in obtaining screening and treatment (Williams, September 1988, p. 13). The purpose of this mandatory service is to ensure that Medicaid-eligible children receive "well-child" and other needed treatment much the same as middle-class children. The federal regulations encourage states to enroll their Medicaid-eligible children with providers who give continuing care and contractually agree to provide all primary care services and make necessary referral for specialty care services (Fox, 1987, p. 33)

As Harriet Fox states in her technical report on Medicaid and services for children and adolescents:

> EPSDT's importance as a potential source of financing appropriate care for severely emotionally disturbed children in states that otherwise offer insufficient community-based services cannot be overstated. Such states can use the EPSDT expanded treatment option to cover services not included in their state plans or to lift restrictions on services that are available but in limited amount, duration, or scope. By expanding coverage policies under EPSDT rather than under the Medicaid program as a whole, states are able to offer additional benefits to the child population only (Fox, 1987, p. 35).

Even though there is great potential in the use of this service because of its inherent flexibility, many states have not used it to serve SED children and adolescents to the extent permitted by law (Fox, 1987, p. 36). EPSDT was designed to fulfill most of the medical needs of Medicaid-eligible children. It can be used for a variety of mental health screening services for all eligible children and adolescents.

Under EPSDT, states were initially required by law to furnish the following services to eligible children:

1. A comprehensive health examination, which includes a health and developmental history, an unclothed examination, appropriate hearing and vision testing, appropriate lab tests, and appropriate immunizations;

2. dental care that includes screening by direct referral to a dentist for children starting at age three and dental care needed for relief of pain and infections, restoration of teeth, and maintenance of dental health; and

3. diagnostic and medical treatment for conditions discovered during the screening process. Treatment services include all services covered under the state's general Medicaid plan; diagnosis and treatment of defects in vision and hearing, including eyeglasses and hearing aids; and immunizations not provided at the time of the screen (CDF, February 1990, p. 3)

Prior to the changes made in the 1989 amendments, discussed below, states had the option of providing services that were reimbursable by Medicaid but not otherwise provided to the general Medicaid population. In Texas, the only service authorized to EPSDT clients was reimbursement for immunizations (TDHS, 1989a, p. 28). Also under the old law, states were required to establish the number of EPSDT screens a child would receive before age 21 and at what intervals they would occur. This periodicity schedule was to be set according to reasonable standards (CDF, January 1990, p. 3).

In FY 1989, 89,162 children in Texas received EPSDT screens. The total cost of the program during that year was $2,994,327 (TDHS, 1989b). Enrollment in the program is not mandatory. However, all Medicaid-eligible children and families must be informed of the existence of the program. Each child enrolled in the program must be given a series of examinations and tests at specific intervals. Providers of EPSDT screens are limited to licensed physicians and health care providers or facilities capable of performing the required medical screening procedures under the direction of a physician (i.e., regional and local health departments, community-based hospitals and clinics, and school districts are eligible to enroll as an EPSDT provider) (TDHS, 1989a, p. 123). In other words, a provider, under the September 1989 regulations, must be able to provide all the required screens in order to be eligible for the program.

A complete screen is reimbursed at a maximum fee of $27. The $27 screening fee includes payment for all laboratory services, including any optional laboratory services the provider may perform that are over and above the required procedures. A follow-up screen is reimbursed at a maximum fee of $6 (TDHS, 1989a, p. 123). The EPSDT screening schedule for Texas is shown in Table 13.6.

The Developmental Assessment screen is important for the identification of emotional disturbance. This screen is to be accomplished for each age group. For physicians enrolled as providers, TDHS recommends that at least the following six elements be included in the assessment:

1. Gross motor development
2. Fine motor development
3. Communication skills or language development
4. Self-help and self-care skills
5. Social-emotional development -- focusing on the ability to engage in social interaction with other children or adolescents, parents, and other adults
6. Cognitive skills (TDHS, 1989a, p. 129)

Nonphysicians may provide developmental assessment screens using a standardized developmental screening test appropriate for the child's age. Acceptable standardized instruments include the Denver Pre-Screening Developmental Questionnaire for ages three months to six years; the Texas Pre-School Screening Inventory for ages four to six years; and the Denver Developmental Screening Test (TDHS, 1989a, p. 129)

Table 13.6. Texas EPSDT Screening Schedule, Periodicity Schedule by Age

Procedure	1 mo.	2 mos.	4 mos.	6 mos.	12-15 mos.	18 mos.	2-3 yrs.	4-5 yrs.	6-10 yrs.	11-15 yrs.	16-20 yrs.
Health/Developmental History	X	X	X	X	X	X	X	X	X	X	X
Vision Testing	X	X	X	X	X	X	X	X	X	X	X
Acuity	X	X	X	X	X	X	X	X	X	X	X
Hearing Testing	X	X	X	X	X	X	X	X	X	X	X
Unclothed Physcial Exam	X	X	X	X	X	X	X	X	X	X	X
Hieght/Wieght	X	X	X	X	X	X	X	X	X	X	X
Hcf	X	X	X	X	X	X					
Blood Presure								X	X	X	X
Developmental Assessment	X	X	X	X	X	X	X	X	X	X	X
Nutritional Assessment	X	X	X	X	X	X	X	X	X	X	X
Urine Testing*											
LABORATORY											
a. Newborn Screening**	X or	X or	X or	X							
b. Hgb or Hct				X or	X or	X or	X		X or	X or	X
c. Lead Screening				X or	X or	X or	X				
d. Rubella Testing										X or	X
e. RPR Card Test										X or	X
f. Hemoglobin Type***										X or	X
g. TB Skin Test					X			X		X or	X
Immunizations		X	X	X	X	X		X		X	
Dental Referral****							X	X	X	X	X

Source: TDHS, 1989b, p. 124

Notes: * Optional
** Complete for children under 12 months who have not been properly tested.
*** At the discretion of the provider as appropriate for age and population groups
**** Dental referrals required for all recipients three years of age and older.
Recipients are allowed a total of six screens during the first two years of life.

One initiative which has been taken by the Texas Commission on Alcohol and Drug Abuse (TCADA) and TDHS is a proposal, approved by the TDHS Board, to amend the state plan to use EPSDT to treat chemically dependent youth. TCADA currently provides funding to licensed facilities for residential and outpatient treatment for chemical dependency treatment. Because of the flexibility of EPSDT, the state would only be required to amend the State Medicaid Plan to include chemical dependency inpatient and outpatient services for those enrolled in the EPSDT program (TDHS, 1989c).

TCADA estimates that fewer than 10,000 Medicaid recipients under age 21 would seek services for chemical dependencies under this provision. Its preliminary estimate indicates that 2,250 Medicaid-eligible youth may seek help and voluntarily enroll in a treatment program. However, one potential limiting factor identified by TCADA is the availability of adolescent beds in residential treatment facilities. It is felt that if reimbursement is available, the number of beds should increase (TDHS, 1989c, p. 1).

TDHS is recommending that Medicaid coverage be limited to children through the age of 20 to a maximum of 270 days per year for residential treatment. It also recommends outpatient group and individual counseling services also be available for reimbursement for treatment of chemically dependent recipients (TDHS, 1989c, p. 2).

One difficulty in using TCADA funds as state match is the amount of funds of federal origin. TCADA state-origin funds would be certified as state matching funds and kept separate from the federal monies. If this can be overcome and the amendment is approved by HCFA, TDHS estimates that the net benefit to the State of Texas could be approximately $5.6 million for the remainder of FY 1990 and $16 million for FY 1991 (TDHS, 1989c, p. 3). Table 13.7 shows the levels of state and federal expenditures estimated if this amendment is approved.

This is only one relatively small example of the potential use of EPSDT to help finance services to SED children and adolescents. TDMHMR also operates a substance abuse unit for adolescents at the south campus of the Vernon unit and could benefit from this effort.

Robert Cole of the Robert Wood Johnson Foundation has shown that by using this mandatory service, states can add Medicaid funds to almost all services provided to Medicaid-eligible children and adolescents. His contention is that the flexibility of this program can encompass many services provided as optional Medicaid services and waivers (Cole, 1989)

Even though the EPSDT program is inherently flexible, most states have not taken full advantage of its potential benefits. EPSDT has provided millions of children access to preventive and primary care. Yet the program has suffered from several weaknesses, some reflecting those of the parent program. These inadequacies led to the legislative pressure to change the regulations. Fist, restrictive eligibility criteria and lack of policies that permit continuous enrollment throughout the year or over several years despite shifts in income have kept many poor children out of the program and have kept millions of children from benefiting from the ongoing health assessment program envisioned by the creators of EPSDT. Second, inadequate rules and procedures and "lackadaisical" federal enforcement of regulations produced four major problems identified by the Childrens' Defence Fund:

1. Lack of specialty screening schedules: The federal statutes and rules contemplate that children will be screened periodically at reasonable intervals for medical, dental, and other problems. Even when schedules for periodic screening visits are adequate for medical care, they often are inadequate for specialized services. For example,

Table 13.7. Projected Program Expenditure for the Extention of EPSDT Coverage for Chemical Dependency Residential and Outpatient Treatment Services

	Dollars in Millions	
	FY 1990	FY 1991
State Funds	$ 10.0	$ 18.6
Federal Funds	$ 15.6	$ 32.6
Total	$ 25.6	$ 51.2

Source: TDHS, 1989d, page 2.

virtually every state has failed to provide a separate periodicity schedule for dental care even though professional standards recommend at least an annual dental visit for older children whereas a medical check-up might be recommended only every two to three years for teens.

2. Grossly infrequent screening schedules: Periodicity schedules vary widely among the states. While the American Academy of Pediatrics recommends at least 20 medical examinations during the first 21 years of a person's life, the number of screens that states now cover ranges from 4 to 30, according to health policy analyst Harriet Fox. During 1989, the Texas Medicaid plan only authorized one visit between the ages of 13 and 21. Long intervals between screens increase the probability that a child's health problems will go undetected or that a suspected problem will grow worse before the child can be examined by a physician.

3. Restrictions on eligible EPSDT screening providers: Many states have rules that limit EPSDT screening participation to those practitioners who can provide a complete screen, that is, both evaluate the physical and mental health of the child and provide vision, hearing, and dental assessment. Screens are typically performed in health clinics, community health centers, and in general practitioners' offices. The drawback to these rules is that providers -- such as pediatricians, expert at assessing a child's physical health, or psychologists, who are perhaps best equipped to perform a developmental assessment -- are excluded from screening because they cannot perform other parts of the screen, such as a hearing or vision exam. By limiting the number of providers allowed to perform EPSDT screens, these rules also have served to limit access to health care for eligible children.

4. Limits on treatment services: The old EPSDT regulations stated that, in addition to any treatment services normally covered under the state Medicaid plan, the state had to provide dental care, appropriate immunizations, and vision and hearing treatment, including eyeglasses and hearing aids. States could decline to provide other services that are reimbursable but not required by Medicaid. For instance, some states have not provided physical or occupational therapy and most states have not provided services needed for substance abusing or seriously emotionally disturbed adolescents. Thus, in many instances under EPSDT, treatment for certain conditions discovered during screens would not be authorized by the state (NHPF, February 1990, p. 4)

The primary impact of the changes contained in OBRA 89 was to ameliorate these defects. The changes in current legislation constitute the most significant improvements since the program's enactment. The National Health Policy Forum identified the following changes to the program:

1. As a result of the EPSDT amendments, health education and anticipatory guidance (health advice to both child and parent) will be required under screening services. Screening services are defined to include the comprehensive assessment of both physical and mental health, an unclothed physical exam, and appropriate lab tests and immunizations.

2. Vision, hearing, and dental services are to have their own periodicity schedule distinct from screening services. The schedules are to be

determined at intervals which meet reasonable standards of medical practice, as determined by the state after consultation with recognized medical organizations involved in child health care."

3. The law now mandates state reimbursement for interperiodic screenings, vision, hearing, and dental services (exams that fall outside of their periodicity schedules), whenever they are medically necessary to determine the existence of a suspected illness or condition. Such screenings were optional prior to OBRA-89. Congress has made clear its intent that the periodicity schedule not interfere with a child's access to needed care. The House report states that an interperiodic exam may take place even when a certain condition or illness has already been diagnosed, if there are signs that the condition is worsening. The new law states that a health, developmental, or educational professional who comes in contact with an EPSDT child can refer the child for an interperiodic screen. Such professionals can include a special education, Head Start, or public school teacher, or a coordinator for Women, Infants, and Children (WIC) Program.

4. The law clarifies that states cannot restrict provider participation to those who can perform the complete service package. Those practitioners who are qualified to provide one or more of the items and services described in the EPSDT service package may provide that service as a partial screen.

5. The change that is potentially the most far-reaching is the requirement that states provide necessary health care, diagnostic services, treatment, and other services reimbursed under Medicaid to correct or ameliorate defects and physical problems discovered by the screening process whether or not such services are covered under the state Medicaid plan (NHPF, February 1990, p. 5)

The potential of these changes in improving services for the Medicaid-eligible SED population should not be underestimated. By far the most significant provision in OBRA-89 is the one that requires states to provide children any necessary services that are federally allowable under Medicaid to treat conditions discovered in a screen, whether or not those services are in the state's Medicaid plan. Before November 1989 a discussion of expanding EPSDT to cover mental health services would include changing the state Medicaid plan and procedures manual. OBRA-89 gives states the opportunity to provide a complete array of mental health services without touching the state Medicaid plan. Combined with the approval of the targeted case management and soon to be approved rehabilitation options, creative use of EPSDT can go far to ameliorate the condition of SED children and adolescents in Texas. At the conference sponsored by this Policy Research Project, Robert Cole of the Robert Wood Johnson foundation emphasized the importance of the changes by saying:

> Essentially, what the OBRA-89 amendments have done is that they've opened the door on what can be done with EPSDT or removed some of the restrictions. First of all they've expanded the number of providers that can do the EPSDT screen. And secondly, they've opened up the services that can be provided so that . . . as long as any state in the country offers a given service through the Medicaid program if the screener writes that service into an EPSDT plan of care, the state Medicaid agency has to pay for it (Cole, 1990)

While EPSDT could vastly increase the scope and range of services offered to low-income SED children and adolescents, some obstacles still exist. While it is required that all eligible children and families be informed of the existence of EPSDT, it is not required that they be enrolled in the program. As a result, most states do not aggressively pursue enrollment of eligible children into the program. This is illustrated in Table 13.8, which shows the 1988 state EPSDT performance indicators for the largest EPSDT-eligible populations.

The first column shows the number of children eligible for EPSDT in each of the states. The second column shows the number of EPSDT screens provided during the same period. Texas, while not the lowest on the list with 24 percent, has a significantly lower participation rate than the national average. Even the national average of 31 percent is not extremely high. In comparison with states that have aggressive Medicaid policies, such as Florida and California, Texas lags far behind.

The differences in screening ratios between age is significant. The screening rates for children five years and under is very good even in those states with low overall screening rates. However, the screening ratios for those over five years of age drops precipitously. This is particularly important when one considers that many signs of emotional disturbance do not manifest themselves until after age six, when a child enters school.

What this table does emphasize is that EPSDT in Texas and elsewhere is not reaching most of the children who are eligible. By not aggressively informing parents about EPSDT and enrolling children into the program, the state can keep its potential liabilities lower. This could be a cost containment method that states will use as limitations on providers and services diminish.

In spite of its inherent flexibility, even before the dramatic changes brought on by the OBRA '89 legislation, not many states have taken advantage of the EPSDT program to fund child and adolescent mental health services. While all states are technically in compliance with the developmental screening criteria, only 7 require any screening for psychological and psychiatric problems and 19 have some expanded mental health coverage under EPSDT (Table 13.1) (Koyanagi, 1988, p. 56). In states where EPSDT has received a priority and mental health factors are included in the screenings, results have been quite impressive. Wisconsin has a computer-assisted outreach program and includes developmental and psychological components in the screen. Oklahoma, using a program pioneered in the State of Washington, provides intensive home-based day treatment as an allowable treatment service under EPSDT (Koyanagi, 1988, p. 57)

Since 1975, the Oklahoma EPSDT program has authorized payment to licensed psychologists. The services of these psychologists can be provided in the office, the hospital, or at the patient's home. Individual, family, or group treatment services are reimbursable to children identified as having emotional or behavioral problems. The only perquisite is that the child be enrolled in the EPSDT program after completion of a "diagnostic encounter" and subsequent development of a treatment plan (ODMH, 1988).

There is special provision for intensive therapeutic services to be provided in the home. The idea behind this service is to reduce psychiatric impairment and prevent removal of a child to restrictive settings. Reimbursable services include a planned combination of procedures developed by a team of qualified mental health professionals. Any array of services that can be found in clinic-based day treatment are reimbursable. Reimbursement is limited to 1-hour units of up to 180 units per year. Services are reimbursed at a rate of $27 per hour. During FY 1989, over 7,600 children were served by community-based services (Graham, Interview, May 13, 1990)

Table 13.8. EPSDT Performance Indicators for Selected States for 1988

State	Number of EPSDT Eligible Children*	Number of EPSDT Screens Provided		Screening Ratios	
			Total	Ages 0-5	Ages 6-20
California	1,620,330	796,712	49.2%	97.6%	14.0%
Florida	293,462	148,377	50.6%	87.0%	22.6%
Illinois	605,020	216,744	35.8%	68.9%	13.6%
Massachusetts	225,985	104,712	46.3%	89.3%	19.0%
Michigan	585,822	123,832	21.1%	31.5%	15.3%
New Jersey	262,055	27,384	10.4%	13.9%	8.4%
New York	951,859	120,321	12.6%	28.7%	2.8%
Ohio	472,927	160,297	33.9%	66.0%	10.9%
Pennsylvania	466,051	132,161	28.4%	55.2%	15.4%
Texas	436,932	97,914	22.4%	39.5%	9.8%
Total	5,920,433	1,928,454	32.6%	57.8%	13.2%
U.S. Total	9,702,677	3,050,034	31.4%	58.9%	13.2%

Source: Childrens' Defense Fund, February 1990.

* Average of four quarterly totals
** Number of screens per 100 eligible children

Available Optional Medicaid Services

There have been optional Medicaid services pertaining to mental health care since the inception of the program (Appendix 13.2). However, changes in Medicaid regulation's over the past decade have given the states more opportunities to add reimbursable mental health and other germane services for children and adolescents. Starting with the OBRA-81 and continuing with the OBRAs of 1985, 1986, and 1987, the number and type of Medicaid-reimbursable mental health services have been expanded.

The optional services that are most important to the coverage of mental health services for children and adolescents are as follows:

1. Institutes for Mental Diseases for Persons 21 and Under
2. Targeted Case Management Services
3. Clinic Services
4. Rehabilitation Services
5. Special Education Related Services

Institutes for Mental Disease for Persons 21 and Under. The option to cover the costs of inpatient mental health treatment for children and adolescents in IMDs for inpatient psychiatric services to individuals under 22 years of age was authorized by Public Law 92-603 (1972 Amendments to the Social Security Act). At that time Texas considered adding this option to the State Medicaid Plan; however, it was felt that private sector participation could not be limited and therefore the state's Medicaid bill could not be controlled (TDMHMR, 1985, p. 1). The proposals to expand coverage for the under-22 population in IMDs have been considered again recently by TDMHMR.

Currently 10 percent of all patients treated in the state hospital inpatient units are age 21 or younger. In 1987, TDMHMR spent a total of almost $185 million for state hospitals. Thus, if $18.5 million is currently being spent on the under-22 population at state hospitals, the addition of this option could mean an additional $10.98 million to the state (assuming that 100 percent of state hospital patients are Medicaid-eligible) (TDMHMR, 1987b, p. 20).

Services eligible for federal matching funds would include room and board, medical care, evaluation/assessments, and psychotherapy. Under this Medicaid option, virtually all of the residential and treatment and rehabilitation services at the state hospital would be eligible for reimbursement. In addition, some expenses related to facility administration and support services would also be eligible for federal matching funds (TDMHMR, 1987b, p. 2). Controls would need to be developed that would limit the desirability of private-sector participation in this option and to control utilization of services per patient (TDMHMR, 1987b, p. 19)

The problem of private-sector participation is a complex issue. More than any other option, covering IMDs for the under-22 population has the greatest potential cost for the State of Texas if adopted. Federal regulations prohibit explicit exclusion of the private sector. The fact that physicians or hospitals make a profit cannot be used to prevent them from participating in the Medicaid program. However, new federal regulations do allow requirements of all providers, including those in the private sector, to be equal to those of the public sector. For example, a state cannot require that only CMHMRCs provide certain Medicaid services. But in establishing qualification for providers of a service a state can require that a provider meet the same standards of practice that CMHMRCs meet. The private sector may object to many standards as being exclusionary, but HCFA has recently upheld, in some cases, the validity of such standards (Touche-Ross & Co., 1988).

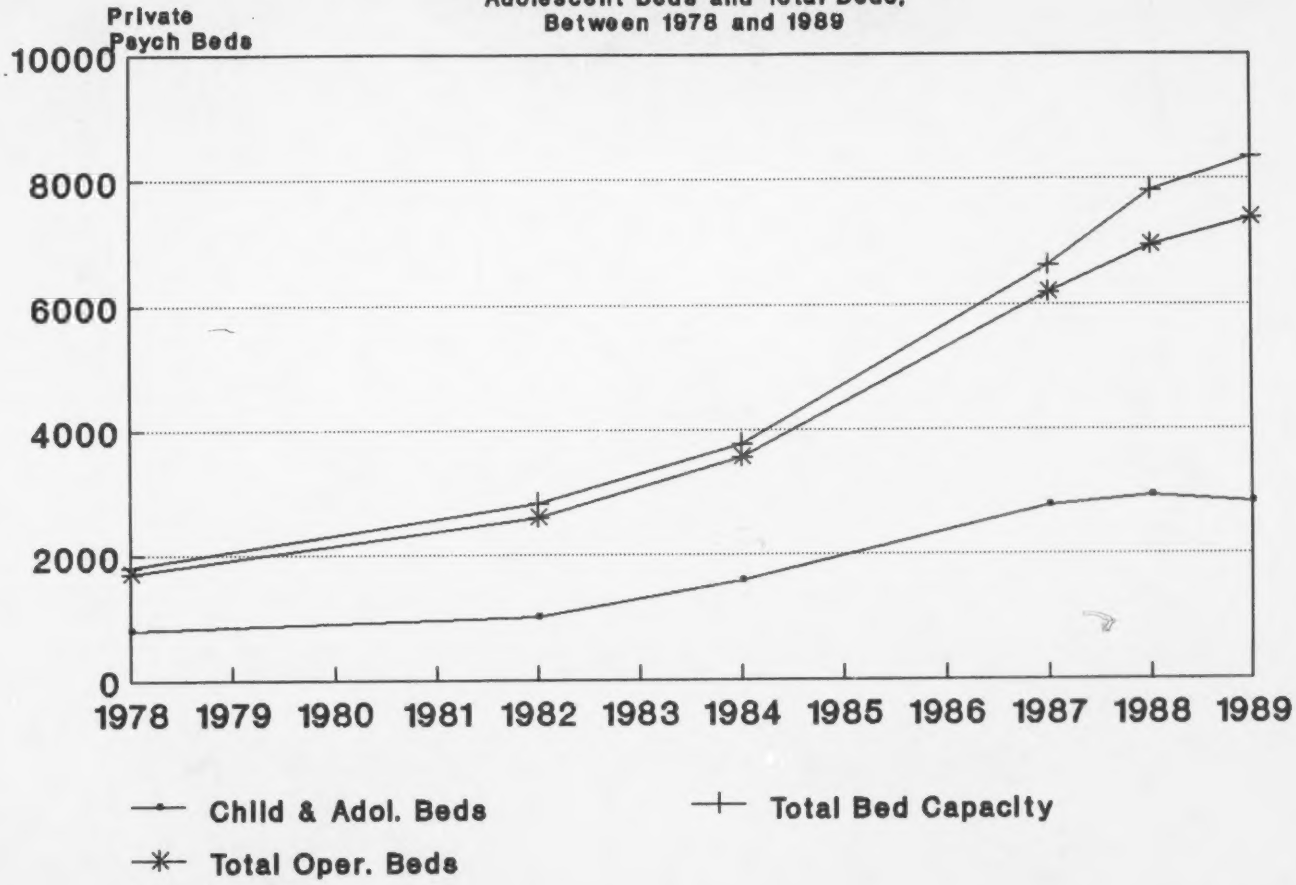
The case of IMDs for those under 22 dramatically illustrates the potential for increased costs of Medicaid expansion. Private mental health care is currently a major growth area. Figure 13.3 illustrates the growth in adolescent and child psychiatric beds in Texas between 1978 and 1989. Table 13.9 lists the growth in all types of licensed psychiatric beds in the state of Texas during the same period. Figure 13.4 further illustrates this trend by showing the dramatic growth in private psychiatric hospitals between 1978 and 1989. The most striking time of expansion was between 1982, when there were 33 private psychiatric hospitals in Texas, and 1988 when there were 80, a 150 percent increase.

These figures come from the annual TDMHMR reports which list the private psychiatric hospitals licensed by the agency and the number and types of beds. The trends show that the increase in child and adolescent beds in private psychiatric facilities is leveling off; after an increase of 6 percent between 1987 and 1988, there was a decrease of 3.5 percent between 1988 and 1989. However, the 182 percent increase from 1982 until 1989 when the population of the state of Texas increased by 25 percent shows that, given the incentive, private psychiatric inpatient services could increase dramatically. The second to last column shows the total beds licensed by TDMHMR that are actually operated by the facilities. The last column shows the number of beds actually licensed by TDMHMR. Figure 13.3 illustrates that since 1984, the total bed capacity, which has grown over three and one-half times since 1978, has been rising faster than the total number of operational beds. As of November 1989, the number of operational psychiatric beds was 88 percent of the total bed capacity. This excess capacity shows that there is the potential for quick growth in utilization given the existing facilities and bed capacity. With approximately 30 percent of the operational beds vacant at any given time (Russell, Interview May 18, 1989), private bed growth can easily accelerate if additional reimbursement is made available through Medicaid and if private providers find the level of reimbursement attractive. The state has limited options to control the growth of the private sector (TDMHMR, 1985).

One strategy to limit involvement of the private sector is to set reimbursement rates so low that private providers would not want to participate in the program. Currently private for-profit psychiatric hospitals charge between $250 and $750 a day for inpatient services, while nonprofit hospitals charge between $150 and $450 per day (TNC, 1989). The state could possibly set a per-day rate for child/adolescent beds at $150. The potential for private-sector participation still exists if the providers prefer to get $150 a day for treating a Medicaid-eligible client rather than get nothing for an empty bed. A 1985 TDMHMR-TDHS study shows that if the private sector had filled 50 percent of the approximately 2,000 child and adolescent psychiatric beds existing at that time with Medicaid-eligible clients, adding IMD coverage would have resulted in no net gain to the state's treasury. Had the private sector filled all 2,000 beds with Medicaid-eligible youth, a net loss of $6 million to $8 million would have resulted (TDMHMR, 1985). Since the number of child and adolescent beds has grown to 2,831 (not including alcohol/drug treatment beds), the potential for significantly increasing costs to the state is very real.

Another point of view is that any expansion of this service would be, in the long run, beneficial to the state in spite of the rise in costs. If more children and adolescents can receive care when they otherwise would not, then this represents another type of gain to the state. If Medicaid-eligible children and adolescents can be treated before their problems become severe enough to warrant the attention of the juvenile justice system, or eventually the adult correctional system, then this could be well worth the added cost to the state. Eventually tax dollars will probably be spent on this population, so it is a question of whether we should spend it now, at a 61 percent discount, or later with the state funds used for 100 percent of the cost. At the same time there is increasing concern that psychiatric hospitals are being inappropriately used for privately insured patients.

Figure 13.3. Trends in Private Psychiatric Bed Growth in Texas, Child and Adolescent Beds and Total Beds, Between 1978 and 1989



Source: TDMHMR 1978; 1982; 1984; 1987a; 1988b; 1989.

Table 13.9 Trends in the Growth of Private Psychiatric Hospitals Licensed by TDMHMR, Types and Totals of Psychiatric Beds at Different Points Since 1978

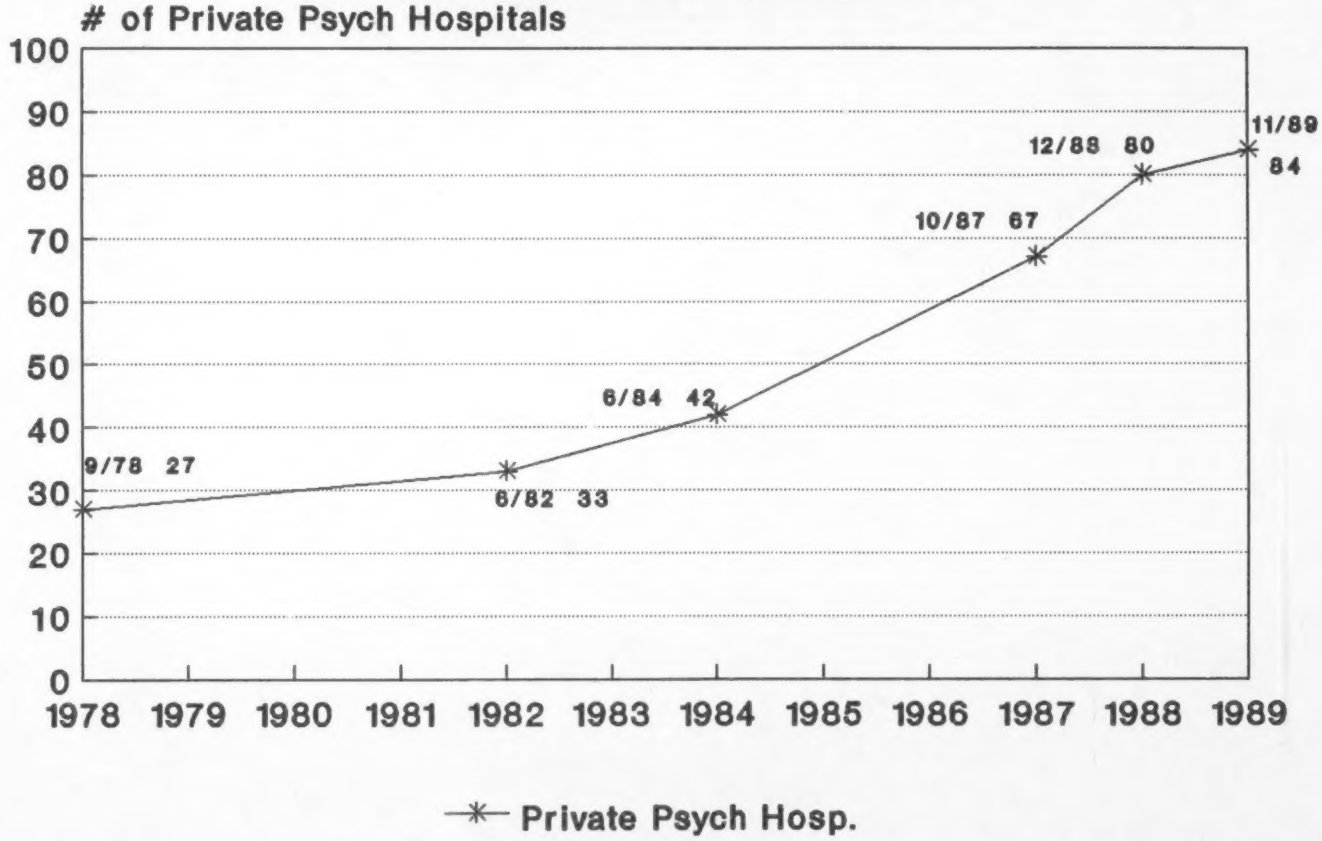
Date of Report	Child and Adolescent Psychiatric Beds*	Adult Psychiatric Beds	Other Types of Beds**	Number of Hospitals	Total Operational Beds	Total Bed Capacity
September 1978	Not Available	N/A	N/A	27	N/A	1,804
June 1982	1,003	N/A	N/A	33	N/A	2,835
Change from Previous Period				22.2%		57.2%
June 1984	1,589	1,549	401	42	3,556	3,773
Change from Previous Period	58.4%			27.3%		33.1%
October 1987	2,766	2,280	1,505	67	6,184	6,631
Change from Previous Period	74.1%	47.2%	275.3%	59.5%	73.9%	75.8%
December 1988	2,938	2,267	1,730	80	6,935	7,808
Change from Previous Period	6.2%	-0.6%	15.0%	19.4%	12.1%	17.8%
November 1989	2,831	2,330	1,901	84	7,373	8,363
Change from Previous Period	-3.6%	2.8%	9.9%	5.0%	6.3%	7.1%
Change from June 1982	182.3%			154.6%		195%
Change from September 1978						363.6%

Source: TDMHMR 1978; 1982; 1984; 1987a; 1988b, 1989.

* There is no standard cut-off for ages in child and adolescent psychiatric beds. In most hospitals the age cut-off between adolescent and adult in 18, and in others it is 21.

** "Other Beds" includes: psychiatric ICU, admissions, both adult and adolescent alcohol and chemical abuse, crisis, geriatric, spiritual, evaluation and observation, intermediate care, acute care, women's center, eating disorders, family unit, longterm, and swing.

Figure 13.4. Trends in the Growth of
Private Psychiatric Hospitals Between
1978 and 1989 in Texas



Source: TDMHMR 1978; 1982; 1984; 1987a; 1988b; 1989.

Targeted Case Management Services. Targeted case management services were added to Title XIX in OBRA 1985. OBRA 1987 added clauses which made it much easier for the states to exclude private-sector participation from this option (Collins, Interview, June 2, 1989). This option allowed states to target case management to specific populations, such as the elderly, pregnant women, AIDS patients, and the mentally ill. States have the option of choosing which group or groups to benefit from case management. These services are defined as those that will assist eligible individuals in gaining access to needed medical, social, educational and other services. This option offers significant opportunities for furnishing comprehensive services to eligible children and their families.

As Harriet Fox states in her technical report for CASSP, "SED children and adolescents are an ideal target group to receive specially designed case management services. Hospital outpatient psychiatric departments, mental health agencies, community mental health centers, and other mental health clinics could be certified as providers. Coverage could include the various family conference and interagency coordination functions that are essential in the treatment of severely emotionally impaired children" (Fox, 1987, p. 39)

HCFA approved Texas' state plan amendment to add targeted case management of the chronically mentally ill in April of 1990. TDMHMR is now billing back to July of 1989 for reimbursement of case management services (Dittmar, Interview, May 14, 1990)

Under the current case management structure, children and adolescents are not widely served. This is primarily because those eligible must fit not only within TDMHMR's priority population but also the more stringent requirements for eligibility to be case managed. Of the 11,372 persons served by TDMHMR case management during FY 1988, only 637 (5.6 percent) were children and adolescents. This number, however, is expected to be increased (TDMHMR, 1988a, summary). If there is an increase in funding, there may also be an expansion of the population served by case management.

Texas is planning to bill Medicaid on a "per-client contact" basis. Every time that a case manager has some kind of contact with a client, no matter the length or substance of the contact, Medicaid will be billed. The per-client contact payment for mental health case management is $31 for a personal contact and $11 for a telephone contact (Dittmar, Interview, January 12, 1990).

For FY 1990, $14 million of state general revenue funds was budgeted for mental health case management services for the mentally ill. A survey of case-managed clients for FY 1988 found that 66 percent of the mental health clients served by TDMHMR are Medicaid-eligible (TDMHMR, 1988a). If we assume that these clients will take up 66 percent of the effort by case management, then an estimated $9.24 million would be eligible for Medicaid reimbursement. This would mean an addition of $5.5 million* in added revenue from case management services. If more funds can be added to case management services, then more persons can be served. The number of children in need of case management services is not readily available, but it is certainly more than the 637 who received services in FY 1988.

Targeted case management has been enthusiastically embraced by many states since it became available in 1985. However, only a few states have developed plans for case-management services that cover SED children and adolescents. Most states have case-management options that target the chronically mentally ill, but the coverage of the nonadult population has been less than adequate. For example, Georgia targets only the most seriously emotionally disabled people, including children, in six of the most populated areas of the state. The program would apply to an emotionally disturbed child or youth who has been "discharged from a hospital two or more times in three months" or who is "living in a community residential treatment facility supported by the [Georgia] Department of Human Resources" (GDHR, 1987, p. 5). Jerry Garber, federal liaison in GDHR's Division of Mental Health, Mental Retardation, and Substance Abuse, pointed out that, although there are "several hundred children with severe emotional disturbances who qualify for case management, less than 25 are now receiving services" (quoted in Williams, November 1988, p. 23).

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* Computed as follows: ($14,000,000 X .66 (percentage Medicaid-eligible clients)/.39 [percentage state match] + (14,000,000 X .34)) - 14,000,000)

North Carolina's case management option was approved in March of 1988. The plan specifically targets emotionally disturbed children and youth under 18. These recipients must have a diagnosis of emotional disturbance or neurological impairment and meet at least one of the following criteria:

1. a serious emotional disturbance that has lasted more than one year or is projected to continue for more than one year
2. a documented developmental delay of more than two years
3. a need for services of more than two agencies
4. a need for more than two services from mental health agencies
5. past treatment in a psychiatric hospital or intensive residential program or a need for such services. (NCDHR, Division of Medical Assistnace, March 1987, P. 2)

This broad definition of who can be served by case management, compared with the restrictions Texas places on who can be served, increases the number of children that can be served. Also unique in the North Carolina case management program is the wide range of providers who can offer (bill for) case management services. Qualified providers include those employed as case managers, licensed RN's, psychiatrists, psychologists, psychiatric social workers, psychiatric nurses, and other licensed practitioners (NCDHR, Division of Medical Assistance, March 1987, p. 2).

Services are billed at a per-client, per-month rate. For children and youth this rate is set at $148. During the first quarter of FY 1989, 339 clients were served at a cost to Medicaid of $197,679 (NCDHR, Division of Medical Assistance, 1989).

Clinic Services. Clinic services were made available to the states during the early eighties. Clinic services are defined as any preventive, diagnostic, therapeutic, rehabilitative, or palliative items or services furnished to an outpatient by or under the direction of a physician or dentist in a facility that is not a hospital (Fox, 1989, p. 37). Of the 55 states and territories, 50 elected to have this option and all but one of those 50 had some provision for mental health services within the option. Texas was not one of the 50.

This option has been the primary mechanism by which states have expanded mental health services to Medicaid-eligible children and adolescents. There are, however, two limitations in the definition of clinic services which have created barriers to service. As pointed out in a recent report on Medicaid expansion, "These limitations include an interpretation by HCFA that clinic services cannot be provided "off-site" and a statutory limitation that these services must be provided under the direction of a doctor or a dentist. These restrictions limit the site of service to a clinic or its satellite facility with appropriate medical supervision. Most states and HCFA have interpreted this to preclude offering home visits, for example, as an allowable service" (Williams, September 1988, pp. 16-17).

Since the addition of the rehabilitative services option to Title XIX in 1987, the clinic services option has become less popular. Some states, such as Florida, have dropped this option completely for the mentally ill population and are using the rehabilitative services option to provide all the services provided under clinic services plus many disallowed by this option (Williams, November 1988, pp. 14-15)

Rehabilitation Services Option. The rehabilitation services option offers significant opportunities for financing mental health services to eligible children and adolescents. This option was added in the OBRA of 1987 in response to complaints about the limitations of the clinic services option. The regulations defined rehabilitation services as any medical or remedial services recommended by a physician or any other licensed practitioner of the healing arts, within the scope of his or her practice under state law, for maximum reduction of physical or mental disability and restoration of a recipient to his or her best possible functional level (Fox, 1989, p. 1)

The regulations put no restrictions on which services are to be provided and who may deliver these services. The only restriction is that these services be recommended by a qualified professional, which is defined by each state. In the Texas application to include this option in the State Medicaid Plan, qualified professionals are defined as MD's, DO's, and mental health professionals or paraprofessionals trained in accordance with the TDMHMR Community Mental Health Standards. However, all services provided must be approved by a physician as a prescribed plan of care (TDHS, 1989d, p. 20).

This flexibility enables states to provide reimbursement for a wide range of mental health services. These might include, in addition to the more traditional treatment interventions, home visiting, crisis intervention, and therapeutic components of care in a specialized foster home, camp, or residential facility. The services may be delivered by anyone who is trained and supervised, but not necessarily licensed or professionally degreed (Fox, 1989, p. 1).

There is the potential for using this option in places where mental health services are not traditionally delivered. One area, for example, is in schools and other facilities where SED children and adolescents can be easily identified. Connecticut has successfully implemented a Medicaid-funded school-based health clinic system using this option that will be discussed later in this chapter. It should be noted that several school districts in Texas are providers of Medicaid services. The Dallas school district is a provider of screening services for the EPSDT program along with several other school systems (Redwine, Interview, August 11, 1989)

On December 15, 1989, TDMHMR and TDHS submitted to HCFA a proposed state plan amendment to extend rehabilitative services to persons with mental illness. As of May of 1990, TDHS and TDMHMR were negotiating the payment methodology to be used (Dittmar, Interview, May 14, 1990). TDMHMR proposes to provide rehabilitative services to:

> persons, regardless of age . . . , who have a single severe mental disorder, excluding mental retardation, and are at risk of institutionalization. At risk of institutionalization includes individuals who, without community support services, would require long-term hospital-based inpatient psychiatric care (TDHS, 1989d, p. 31a).

The State of Texas wishes to include a variety of services for this population that are already paid for through state funds. This option would include most services provided by CMHMRCs. The State Medicaid Plan includes a detailed list of services to be provided. A synopsis of these services is included in Table 13.10.

Table 13.10. Synopsis of Services to be Provided by Texas Rehabilitative Services for Persons with Mental Illness

Services Included in Texas Rehabilitaion Option

1. Evaluation and/or functional assessment/reassessment.
2. Crisis Resolution.
3. Medication Maintenance.
4. Medication Monitoring.
5. Medication Training.
6. Structured Rehabilitatie day/evening Treatment Programs.
7. Rehabilitative Therapies for increasing daily living skills.
8. Psychological Rehabilitation Services.
9. Routine Interventions (not available for those receiving Medicaid Case Management Services).
10. Collateral Interventions with Other Professionals.
11. Transportation.

Rehabilitative Services would not include

-Room and Board Residential Costs
-Educational Services
-Inpatient Hospital Services
-Services to Individuals with Developmental Disabilities that are non-psychiatric in nature.
-Services in excess of established benefit limits.
-services that area an integral and inseparable part of another Medicaid reimbursable service.

Source: TDHS., 1989d. Page 31b-31c.

TDMHMR and TDHS felt that it was prudent to include several limitations on providers. The qualifications on providers is a typical example of how states can limit participation in Medicaid options to only public-sector providers. The state plan amendment specifies that providers must meet several very restrictive qualifications. These include providing services regardless of ability to pay; providing all core services required by TDMHMR of CMHMRCs; keeping extensive auditing records; and meeting the TDMHMR Mental Health Community Standards (TDHS, 1989d, p. 31d).

TDHS and TDMHMR are now working on establishing a payment system for this option. The plan is to develop a prospective cost-based, statewide, uniform reimbursement system on a fee-for-service basis. For the initial reimbursement periods for this program, the rate for each service is based on projected expenses required to provide each service. The projected expenses will be based on the number of staff required to comply with the program standards (TDHS, 1989d, p. 20). The cost structure will emerge as negotiations with HCFA progress.

As can be seen in Table 13.10, the potential scope of these services is extremely broad and extremely important. A 1987 joint study by TDHS and TDMHMR estimated that the inclusion of this option could potentially bring in $50 million in additional funds. This cost estimate was based on the assumption that roughly 48 percent of the people served in CMHMRCs and state hospital outreach clinics might be Medicaid-eligible. After subtracting administrative costs not associated with treatment and other non-Medicaid-eligible expenses, it is estimated that $83 million is spent on services covered under this option (TDMHMR, 1987b). It is difficult to extend these estimates to the amount of extra funds needed for the treatment of SED children and adolescents since the CMHMRCs do not break down their costs by age groups served. But the increased services to this population that could result from inclusion of this option would certainly ameliorate the identification and condition of SED children and adolescents in Texas.

Since 1984, Florida has been operating a rehabilitation program for mentally ill Medicaid-eligible children and adults. This option replaced all of the services contained in their clinic services option. The Florida state Medicaid plan provides for reimbursement for four categories of services:

1. evaluation and testing
2. counseling, including various kinds of psychotherapy
3. vocational rehabilitation counseling and social rehabilitative services
4. day treatment

Each Medicaid-eligible recipient is given an individual treatment plan, which outlines the diagnosis, treatment objectives, and services to be provided. There are no restrictions on treatment sites. The Medicaid-eligible children receive services in a variety of different locations, such as in clinics, the home, schools, day treatment sites, and foster homes. The 85 providers of rehabilitation services range from community mental health centers to free-standing alcohol and substance abuse centers (Williams, November 1988, p. 16).

The portion of this program for those under 21 years of age has grown markedly since its inception. In 1984 about $1.6 million in Medicaid funds were expended for these services. In 1988 $2.7 million was spent for this population. Under the clinic option only about $600,000 was spent for the under-21 population. For both children and adults the rehabilitation option was expected to bring in more than $19 million [in federal funds] in FY 1989 (Williams, November 1988, p. 17).

Florida has used the expansion of Medicaid to cut state expenditures on these services. While federal dollars for mental health services were immediately increased, the level of state funding was cut back; therefore, no additional dollars were available at the service delivery level (Williams, November 1988, p. 18).

Special Education Related Services. While this is not an official optional service, recent court cases have established that many services provided to Medicaid-eligible special education children are reimbursable. Related services are defined as transportation, developmental, corrective, and other supportive services which are required to assist a handicapped child to benefit from special education. These can include such Medicaid-eligible services as psychological services, physical and occupational therapy, medical counseling, and services for diagnostic and evaluative purposes (Williams, September 1988, p. 18).

The problem with charging these services to Medicaid was that HCFA originally denied these types of claims, arguing that if a service was included in an individual education plan as required by PL 94-142, it could not be paid for by Medicaid even if the child was eligible and the service was an allowable Medicaid service. Massachusetts appealed this decision and won. The court of appeals ruled that the federal government could not deny payment solely because the service was included in an IEP. The court further said that the USDHHS's position was based on an artificial distinction between a social welfare department administering Medicaid and an education department. During 1987, Congress further clarified its position in PL 100-203, which stipulates that nothing in the Medicaid law can be construed as prohibiting or restricting payment for medical services for a handicapped child because such services are included in the child's IEP. With this recent clarification and with the legislative extension of PL 94-142 to include the population from birth to three years of age, it can be expected that states will begin to take a much closer look at the ability of the Medicaid program to pay for "related services" for eligible handicapped children (Williams, September 1988, p. 19)

Home-and Community-Based Waivers. The first major expansion was the creation of the Home-and Community-Based Waiver Program. This waiver program was designed to help pay for community placements for people who would otherwise be in more expensive nursing homes or other inpatient settings being paid for by Medicaid. Moreover, many states have been reluctant to apply for this waiver because of the restrictions that expenditures under the waiver be less than if there were no waiver (Vischi, June 1988, p. 68). Texas has used this waiver program for the mentally retarded. Since Texas has extensively used the state school system for the institutionalization of the mentally retarded, it was easy to show that the home- and community-based waiver would be cost effective. During FY 1989 the annual expense for this waiver was $10.3 million spent on serving 739 clients (TDHS, 1989b). Since Texas did not cover institutes for mental diseases for patients under 21 at the time this section was passed, it could not be shown that the waiver program would be revenue neutral for the mentally ill population.

Vermont is the only state that has received a home- and community-based waiver to serve severely emotionally disturbed children and adolescents. The services included in the waiver were case management, family training and support, respite care, and social and recreational services (i.e., intensive home-based services) for children and adolescents living at home, training in home management and basic skills for those living in residential group homes, and family training and respite care for those placed in professional foster care setting (Fox, 1987 p. 53)

School-Based Services

Health clinics based in schools could be one of the most effective ways of identifying and treating children with neuromuscular and other problems as well as SED children and adolescents. Currently there are over 160 school-based health clinics in operation nationwide, with an increasing number offering mental health services. With few exceptions, the clinics are run by agencies other than the school itself: local health departments, hospitals, or mental health agencies. The schools usually provide some funding or in-kind contributions such as space, equipment, or services of a nurse already on the school staff (McCormick, 1989, p. 57). While the locus of attention on school-based clinics has centered on the birth control/abortion issue, there is increasing interest in using school-based clinics to deliver mental health services.

Schools can be extremely important as potential locations of mental health services for children and adolescents. It is often in the schools that emotional problems first begin to appear and where identification is most easily accomplished. If the mechanism for locating mental health clinics were in place, many drastic forms of intervention could be avoided. One way of going about this is to have the school-based mental health clinics be satellite locations of the CMHMRCs or the state hospital outreach clinics.

The involvement of Medicaid in the delivery of services to school-based clinics is extremely important. Independent school districts throughout the [illegible] of Texas have long been providers of health-related services. The Dallas school district is a qualified provider of EPSDT screening services. The Early Childhood Intervention program (though primarily state-funded) lists several independent school districts as contractors.

When the EPSDT program is expanded to include mental health screening and treatment or when the rehabilitation option is adopted, the expansion of services to schools would not be difficult. These satellite locations of the local mental health authorities could be approved as vendors of Medicaid-eligible services.

The Connecticut School-Based Clinic Program

The Connecticut State Department of Education, in a joint effort with the Connecticut State Department of Income Maintenance, initiated the School-Based Child Health Services Program for the Hartford School District in 1985. The program has been expanded to the entire state. This program receives Medicaid reimbursement for "related services" included in the child's IEP. These related services are covered under the state's Physicians' Services and Rehabilitation sections of its State Medicaid Plan (TRL, March 1989, p. 54)

The Hartford School District has an enrollment of about 25,000 students, which would rank as one of the 25 largest school districts in Texas. The school district's special education program serves 4,200 students, of which approximately 1,500 receive speech therapy, 1,000 receive counseling services, and 100 receive physical and/or occupational therapy. During the first seven months of the 1988-1989 school year this program received $366,000 of its funding from Medicaid (TRL, March 1989, p.54).

When students are enrolled in the program, they are assessed and evaluated by a supervising physician who then recommends what services are to be included in the student's individual education plan (IEP). Because payment is authorized through the state's physicians' services program and the rehabilitation option, the following services are covered:

1. Physicians' Services
2. Speech, Hearing, and Language Services
3. Occupational Therapy Services
4. Mental Health Services
5. Physical Therapy
6. Respiratory Services
7. Laboratory Services
8. Medical Transportation (TRL, March 1989, p. 56)

The Department of Income Maintenance certified the school district as a Medicaid provider. However, according to an agreement between the department and the school district, school district staff providing services must have their own provider number. Consequently all staff involved in the school-based clinic program are certified Medicaid providers (TRL, March 1989, p. 55).

Medicaid claims are submitted monthly on standard HCFA forms. The services are billed in 15-minute units. All bills are submitted through a single billing agent. The Capital Region Education Council is designated as the third-party billing agent. This council bills all possible payees (insurance companies, parents, etc.), including Medicaid as the payor of last resort (TRL, March 1989, p. 55).

Participation by school districts in this program is voluntary. As a result, even though this program is available statewide, only 6 school districts out of 150 in the state have elected to use this program. It is theorized that school district participation in the program is low because local school boards are not fiscally independent entities. Most federal funds received by the Connecticut school districts normally flow into the city treasury. Consequently, in Hartford, a special funds account was created to handle Medicaid reimbursement funds. This was done to ensure that Medicaid reimbursements were not commingled with city funds and spent on municipal projects rather than set aside for school district purposes (TRL, March 1989, pp. 56-57).

While this program has not been completely successful, it does show that Texas can expand services to the schools that would benefit SED children and adolescents. The Connecticut program has not been able to reach most of the children throughout the state and the third-party billing system has not been successful. The importance of this program as an example to Texas is pointed out in a report by the Texas Research League, "In the final analysis, the wide array of provider settings and provider types in conjunction with sufficient optional health services buttressed by a current data base proved a potent mix for the state Connecticut: A prescription for effective and maximum use of federal, state and local funds" (TRL, March 1989, p. 58).

Supplementing versus Supplanting State Funds

One concern from the point of view of adequate services, as shown by the Florida example, would be the temptation of legislators to use Medicaid to supplant state dollars spent on mental health services. For example, if the legislature saw that TDMHMR case management was getting an extra $5 million from Medicaid in addition to a state appropriation, they might want to cut back the budget by that amount. This would result in the inability to expand this important service to other non-Medicaid-eligible persons. In these times of fiscal stress for Texas or at any other time, there is the possibility that the legislature could use the increase in federal funds as an excuse to cut the state budget for mental health services. If ways can be found to safeguard funds for services, the traditionally underfunded mental health delivery system in this state would be greatly improved.

Strategies used by the Connecticut system by which funds are sent to a special account for the schools could be effective. In Texas, the federal portion could be sent directly to the quasi-independent CMHMRCs for services rendered as a provider. For school-based clinics funds could be sent directly to the clinics. As long as proper accountability is maintained there should be no real problem with this approach. However, any approach cannot completely safeguard the withdrawal of state funds for programs eligible for reimbursement. However, even if state funds are withdrawn, having the framework available for future expansion of services would be extremely beneficial to the delivery services.

CONCLUSIONS

Texas currently spends millions of dollars out of the state general revenue fund and from local tax dollars to pay for mental health care of SED children and adolescents. However, even with these expenditures, residential care and community-based care for this segment of our population is inadequate. Medicaid can help in financing services, but it is not the secret elixir which will cure all of the funding problems for SED children and adolescents.

For example, in order to implement a system of school-based mental health clinics, significant amounts of state funds will have to be expended for their establishment. Local school districts will not be willing to shoulder many of the costs associated with these programs. Since the state cannot exclude all private providers from the IMDs for those under 22, it does not participate in this option. As a result, many Medicaid-eligible children and adolescents do not have access to residential treatment when it is needed. Expansion of the EPSDT program to cover mental health services for those under 21 would cost the state money. OBRA-89 has opened the door for Texas to do this without many of the bureaucratic difficulties previously experienced. The current state Medicaid system covers very limited psychological treatment. If the program were expanded to cover these services, the state would still have to come up with its 39 percent share of the matching funds.

While the rehabilitation option would make reimbursable many services needed by SED children and adolescents, these are services that are not reaching many children and adolescents at this time. Extra state funds would have to be expended to identify and provide services to those who are not now being served.

But to take the view that these services will cost extra monies now and therefore the state should not proceed is short-sighted. There will come a time when the state will pay for its neglect. SED children and adolescents must wait until their condition deteriorates to the point where they become severe enough to be served by the local CMHMRCs or until they warrant inpatient care at state expense. Many of these SED children and adolescents are not served until they come to the attention of the juvenile justice system. City, county, state, and federal funds from various programs must then be expended for their probation, adjudication, or incarceration.

The cost to the state once these children reach adulthood is immeasurable. Services are provided by the state through the Department of Corrections and in the state hospital system. This is on top of the lost tax revenue from those people who could have become productive working citizens but did not receive treatment in a timely manner. If their problems are identified, diagnosed, and treated early enough, the possibility of avoiding more expensive approaches further down the road is greater. The Medicaid match gives Texas the opportunity to provide these preventive measures at a 61 percent discount.

Appendix 13.1. Mandatory Medicaid Services

1. Inpatient Hospital Services - not including services in institutions for tuberculoisis or mental disease, must be provided in licensed hospitals and be directed by physicians or dentists.

   In FY 1989 in Texas Annual Expense: $505,408,922 Clients Served: 268,649

2. Outpatient Hospital Services - includes preventive, diagnostic, therapuetic, rehabilitative, or paliative services provided to hospital out patients.

   Annual Expense: $110,459,508 Clients Served: 474,875

3. Rural Health Clinic Services - provided in certified clinics. There were no rural health clinics enrolled in Texas Medicaid during FY 1989.

   Annual Expense: 0 Clients Served: 0

4. Laboratory and X-Ray Services

   Annual Expense: $ 7,016,698Clients Served: 131,699

5. Skilled Nursing Facility (SNF) & Intermidiate Care Facilities (ICF) Services - Provided for individuals over the age of 21, but not including institutes for tuberculosis ormental disease.

   1,010 Facilities 102,606 Beds
   Annual Expense: $712,800,000 Clients Served (per month): 61,697

6. Physicians' Services

   Annual Expense: $272,387,831 Clients Served: 1,030,586

7. Early and Periodic Screening, Diagnosis and Treatment (EPSDT) - Provided to recipients under 21 to identify physical or mental defects and provide treatment to correct them.

   EPSDT Dental
   Annual Expense: $14,644,614.64 Clients Served: 141,008

   EPSDT Medical
   Annual Expense: $ 2,994,327.40 Clients Served: 89,162

8. Family Planning Services

   Annual Expense: $ 4,856,003.68 Clients Served: 58,160

9. Home Health Services - This includes part-time or intermittent nursing services in the recipient's home.

   Annual Expense: $ 1,687,402.73 Clients Served: 2,817

10. Licenced Nurse-Midwife Services - For mothers and newborns.

    Annual Expense: $61,790.62 Clients Served: 792

Source:TDHS. 1989b

Appendix 13.2. Optional Medicaid Services

1. Other Licensed Practitioners - Medical or remedial care provided by chiropractors, optometrists and podiatrists.

   In FY 1989 in Texas Optometrist Services
   Annual Expense: $ 12,041,674 Clients Served: 229,680
   Chiropratic Services
   Annual Expense: $ 178,016 Clients Served: 2,568

2. Additional Home Health Services - Includes physical and occupational therapy, speech pathology and audiology services.

Hearing Aid	Annual Expense: $	967,106	Clients Served:	4,477
Home Health	Annual Expense: $	1,687,402	Clients Served:	2,817

3. Private Duty Nursing Services - Provided in the recipients' home, a hospital or SNF when more than routine service is required.

4. Clinic Services - Includes any preventive, diagnostic, therapeutic, rehabilitative, or palliative items or services.

   Not Covered in Texas

5. Dental Services

6. Physical Therapy Related Services

7. Prescriptions - Includes drugs, dentures, prosthetic devices, orthopedic shoes, and eyeglasses.

8. Diagnostic, Screening, Preventative and Rehabilitative Services (Rehabilitation Option)

   State Plan Amendment Pending at HCFA

9. Inpatient Hospital/Intermediate Care Facility (ICF) and SNF Services - For recipients over the age of 65 in tuberculosis and mental disease institutions.

   Not Covered in Texas

10. ICF Services for the Physically ill or Mentally Retarded

11. Inpatient Psychiatric Hospital Services for Individuals Under Age 21

    Not covered in Texas

12. Other Medical or Remedial Care - This includes transportation to obtain needed medical exams and treatment, emergency hospital services, Christian Science nurses and sanatoria, SNF services for individuals under 21, and nonprofessional care and services.

Abulance Services	Annual Expense: $	5,929,326	Clients Served:	47,376
Abulatory Surgical Ctr	Annual Expense: $	1,734,658	Clients Served:	6,222
Birthing Center	Annual Expense: $	70,813	Clients Served:	337
Dentist Services	Annual Expense: $	70,813	Clients Served:	

Appendix 13.2 (continued). Optional Medicaid Services

13. Primary Home Care - Includes personal care services, homemanagement and escort services.

Annual Expense: $122,800,000 Clients Served: 33,808

14. Targeted Case Management Services - Allows states to provide case management services to specific populations such as the chronically mentally ill, AIDS patients, the elderly.

State plan Amendment for mental health case management approved by HCFA in April 1990

15. Day Activity and Health Services - Adult day health care facilities.

Annual Expense: $ 5,100,000 Clients Served: 1,520 (per month)

16. Home-and Community-Based Waivers - These include case management, homemaker, home health aide, personal care, adult day health, habilitation, respite care, and other services.

Medically Dependent Children - HCFA Approved $1,074,056 for 6/29/89 - 6/28/90

Mentally Retarded Annual Expense: $ 10,300,000 Clients Served: 739

Source:TDHS. 1989b.

References

Children's Defense Fund (CDF). January 1990. "Analysis of 1989 Federal Legislation: Medicaid Preventive Services for Children -- The Early and Periodic Screening, Diagnosis, and Treatment (EPSDT) Program." Washington, D.C. Unpublished Memo.

__________. February 1990. "New Opportunities for Preventive Health Care for Poor Children: Medicaid's EPSDT Program after 1989 Federal Legislation." Washington, D.C. Unpublished Memo.

Cole, Robert F., Deputy Director of Mental Health Services Program for Youth, Prudential Insurance Company. 1989. "Activities of the Robert Wood Johnson Foundations Programs for Severely Emotionally Distrubed Youth." Presentation to Policy Research Project, Lyndon B. Johnson School of Public Affairs, Austin, Texas. (November 12.)

__________. 1990. "Financing Mechanisms." Presentation to a conference on "Youth in Texas: Financing and Coordinating Care for Severly Emotionally Disturbed Children and Adolescents in Texas." Austin, Texas. April 6.

Collins, Janet. 1989. Director of Case Management Services, Texas Department of Mental Health and Mental Retardation. Austin, Texas. Interview by Nicholas Hoover. June 2.

"For the Record: Provision; Deficit Reductions Bill Offers $14.7 Billion in Cuts." 1989. Congressional Quaterly. (December 16.)

Dittmar, Nancy. 1989. Director of Special Programs, Texas Department of Mental Health and Mental Retardation. Austin, Texas. Interview by Nicholas Hoover. November 13.

____________. 1990. Interview by Nicholas Hoover. Austin, Texas. January 12 and May 14.

Fox, Harriette B., with Ruth Yoshpe. August 1987. An Explanation of Medicaid and Its Role in Financing Treatment for Severely Emotionally Disturbed Children and Adolescents.-- A Technical Report. Washington, D.C.: Georgetown University Child Development Center, CASSP Technical Assistance Center, and Fox Health Policy Consultants.

Fox, Harriette B. March 1989. An Addendum to: An Explanation of Medicaid and Its Role in Financing Treatment for Severely Emotionally Disturbed Children and Adolescents.- A Technical Report. Washington, D.C. Georgetown University Child Development Center, CASSP Technical Assistance Center, and Fox Health Policy Consultants.

Georgia Department of Human Resources (GDHR). 1987. Transmittal and Notice of State Plan Material for: Health Care Financing Administration: "Implementation of Rehabilitative Services for Persons with Mental Illness." Form OMB No. 0938-0193. Atlanta, Georgia. (November 15.)

Graham, Marla. 1990. Director, Children in Need of Services Program, Oklahoma Department of Mental Health. Telephone Interview by Nicholas Hoover, Oklahoma City, Okla., (May 14.)

Jung, Ronnie. 1990. "Financing Trends and Arrangements" in Financing Care for the Chronically Mentally Ill in Texas. Policy Review Project, Lyndon B. Johnson School of Public Affairs, Austin, Texas. Forthcoming.

Koyanagi, Chris. 1988. Operation Help: A Mental Health Advocates Guide to Medicaid. Alexandria, Virginia: National Mental Health Association.

McCormack, Maureen P. 1989. Comparison of Health Care Programs for the Indigent in Texas and California. Professional Report, Lyndon B. Johnson School of Public Affairs, Austin, Texas.

McCormick, Kathleen. 1989. "Bringing Health Care to the Kids." Governing. (September)

National Association of State Mental Health Program Directors (NASMHPD). January 1987. "Utilization of Medicaid Reimbursement for Community-Based Mental Health Services: Proceedings from a State-Of-The-Art Symposium held September 30 and October 1, 1986 in Crystal City, Va." Arlington, Virginia.

National Health Policy Forumn (NHPF). February 1990. "EPSDT and Increased Health Care for Low-Income Children: Prospects and Problems for the States." Issue Brief Number 539. Washington, D.C.: George Washington University.

North Carolina Department of Human Resources (NCDHR), Division of Medical Assistance. March 1987. "State Plan Under Title XIX of the Social Security Act. State of North Carolina, Case Management Services." HCFA-PM-87-4. Supplement 1 to Attachment 3.1-A. Raleigh, North Carolina.

___________. 1989. "Counts by Procedure Code of Mental Health Case Management Clients. Source: Paid Claims Oct-Dec 1988 (Adjs Excluded)." Raleigh, N.C. (January 23) (Computer printout.)

Oklahoma Department of Mental Health (ODMH). 1988. "Oklahoma State Medicaid Plan as It Pertains to Mental Health Services." Oklahoma City, Okla.

Redwine, Augustine. 1990. Analyst, Texas Research League. Austin, Texas. Interview by Nicholas Hoover, January 11.

Roberts, Chuck. 1990. Budget Analyst, Texas Department of Mental Health and Mental Retardation. Letter to Nicholas Hoover, (April 15.)

Russell, Rush. 1989. Revenue Officer, Texas Department of Mental Health and Mental Retardation. Austin, Texas. Interview by Nicholas Hoover, May 18.

Texas Department of Human Services (TDHS). 1988a. Income Assistance Handbook, Appendix MP C-120, "Medically Needy Needs Allowance Chart." Austin, Texas.

___________. 1988b. "The Quarterly Blue Book: A Compilation of DHS Statistics for May 1988." Austin, Texas. May.

___________. 1989a. Medicaid Provider Procedures Manual. Austin, Texas.

___________. 1989b. "Individual Service Profiles Texas Medicaid Program Contracted Client Services." Austin, Texas.

___________. 1989c. "Memo from Ron Lindsey, Commissioner, to the Chairman and Members of the Texas Board of Human Services." Austin, Texas.

___________. 1989d. Transmittal and Notice of State Plan Material for: Health Care Financing Administration. "Implementation of Rehabilitative Services for Persons with Mental Illness, Texas Amendment #249." Form OMB No. 0938-0193. Austin, Texas. December 15.

Texas Department of Mental Health and Mental Retardation (TDMHMR). 1978. "Private Mental Hospitals Licensed by TDMHMR." Austin, Texas.

___________. 1982 "Private Mental Hospitals Licensed by TDMHMR." Austin, Texas. (June 2.)

___________. 1984. "Private Mental Hospitals Licensed by TDMHMR." Austin, Texas.

___________. 1985. "Extending Medicaid to Cover Mental Health Services: A Report to the Lieutenant Governor." Austin, Texas. (March 15.)

___________. 1987a. "Private Mental Hospitals Licensed by TDMHMR." Austin, Texas. (October 27.)

___________. 1987b. "Federal Funding Issues." Austin, Texas.

___________. 1988a. "TDMHMR Case Management Services: Evaluation for Fiscal Year 1988." Austin, Texas. (October 3.)

___________. 1988b. "Private Mental Hospitals Licensed by TDMHMR." Austin, Texas. (December 23.)

___________. 1989. "Private Mental Hospitals Licensed by TDMHMR." Austin, Texas. (November 6.)

Texas Legislature, Select Committee on Medicaid and Family Services. 1988. "Final Draft: Local Funds Subcommittee Report to the Select Committee on Medicaid and Family Services." Austin, Texas. (September 21)

Texas Network for Children (TNC). 1989. "TNCinfo, Version 2.0: TNC's Computerized Information & Referral System." Austin, Texas.

Texas Research League (TRL). March 1989. "The Benefits of and the Obstacles to Medicaid Program Expansion: a Report to Lieutenant Governor William P. Hobby." Austin, Texas.

Touche-Ross & Co. 1987. "Final Report on Review of Opportunities for Prospective Medicaid Funding for Mental Health and Mental Retardation Services in Texas." Texas Department of Mental Health and Mental Retardation, Austin, Texas.

__________. 1988. "Federal Participation in Community Support and Case Management Services." National Association of State Mental Health Commissioners, Community Support Program Directors, Austin, Texas. (October 26.)

U.S. Congress. 1989. Omnibus Budget Reconciliation Act of 1989. Public Law 101-239 - December 19, 1989. Washington, D.C.: U.S. Government Printing Office.

U.S. Congress, House of Representatives, Committee on Energy and Commerce, Subcommittee on Health and the Environment. November 1988. Medicaid Source Book: Backgroud Data and Analysis. A Report Prepared by the Congressional Research Service. Washington, D.C.: U.S. Government Printing Office.

U.S. Congress, House of Representatives, Select Committee on Children, Youth, and Families. August 1985. "Opportunities for Success: Cost-Effective Programs for Children." Washington, D.C.: U.S. Government Printing Office.

U.S. Congress, Office of Technology Assessment (OTA). December 1986. Children's Mental Health: Problems and Services, Background Paper, OTA-BP-H-33, Washington, D.C.: U.S Government Printing Office.

U.S. Department of Health and Human Services, Health Care Financing Administration, 1987. Analysis of State Program Characteristics, 1986. Draft Copy.

__________. January 1988. "State Medicaid Manual - Part 4 - Services." HCFA publication #45-4. Washington, D.C.

Vischi, Thomas R. June 1988. "Financing Community Services for Persons with Severe and Disabling Mental Illness: A Technical Assistance Manual." Washington, D.C.: National Institute for Mental Health. Alcohol, Drug Abuse, and Mental Health Administration.

Williams, Sara. September 1988. Using Medicaid to Increase Funding for Home-and Community-Based Mental Health Services for Children and Youth with Severe Emotional Disturbance. A Technical Report. Georgetown University Child Development Center. Washington, D.C.: CASSP Technical Assistance Center.

__________. November 1988. Using Medicaid to Increase Funding for Home-and Community-Based Mental Health Services for Children and Youth with Severe Emotional Disturbance: A Report on CASSP Workshop Held on September 15 and 15, 1988, in Bethesda Maryland. Georgetown University Child Development Center. Washington, D.C.: CASSP Technical Assistance Center.

Chapter 14. Conclusions

In general, children with serious emotional disturbance in Texas are unable to find appropriate services for their needs. This is due to deficient state funding, lack of coordination of services between agencies, and insufficient noninstitutional services for children at risk (Mental Health Association, 1989; Hogg Foundation, 1990). The consequences of these deficiencies are painful and far worse than increasing the services and improving coordination now. Advocates and agency personnel have begun to put together a plan for Texas, but unless the state provides funding and mandates coordination at the local level, the progress which can be achieved is likely to be limited. In this chapter we will summarize some of the findings and problems identified in the report. We present some of the conclusions and proposed initiatives of state and foundation task forces, including the Texas Childrens' Mental Health Plan, and finally we identify some of the continuing issues which must be addressed by the state.

SUMMARY OF FINDINGS

Although covered in much greater detail in this report, the major findings of this study are worth reiterating.

The Schools and the Texas Education Agency (TEA)

The schools have the potential to play the major role in coordinating services for children and youth since they are the institutions that serve all youth, at least between the ages of 5 and 16. Two-thirds of the school districts in the state identify fewer than .5 percent of their students as emotionally disturbed, although federal estimates state that 3 to 4 percent are generally eligible for an SED program. This lack of identification leads to only a small number of persons eligible for special programs, and it also means that the state receives less funding from the federal government for special education. For students who are identified, programs are often quite limited. Day treatment facilities and crisis centers are not available in many school districts, and there is little or no coordination with the mental health system.

The Texas Department of Mental Health and Mental Retardation (TDMHMR)

Although there are inpatient services in the state hospitals and the Waco Center for Youth, there is a severe lack of public mental health beds for nonpsychotic violent children. There is a major shortage of intermediate care and family support services. This includes case management, therapeutic foster care, respite beds, day treatment and home-based services. Most of the Community Mental Health and Mental Retardation Centers (CMHMRCs) have provided very minimal services to children and youth. The initiation of a children's mental health coordinator, a CASSP advisory group, and $2 million for four demonstration sites in improved Community Mental Health Center programs and one site for a joint program with the Texas Juvenile Probation Commission, are all encouraging developments. However, as an example of how limited current funding is in Texas, TDMHMR estimated that $474.3 million in additional funds would be required to implement the North Carolina model system of care for children.

The Texas Department of Human Services (TDHS)

Due to limited funding, less than half (26,241 cases) of the 63,076 cases of confirmed child abuse and neglect needing services after investigation actually received services in 1987. Since the department does not even investigate cases in which children are reported to be at risk of abuse or neglect but have not actually been harmed, the department's ability to effectively prevent child abuse is limited. Since TDHS pays facilities for the emotionally disturbed in substitute care below their cost, and pays level V and VI facilities very much under their cost, no providers are willing to provide therapeutic foster care even though it could be less costly than residential treatment facilities. Similarly, TDHS has very limited in-home services which could effectively prevent abuse and severe emotional disturbance by enhancing the capacities of families. Partial matching funds from the federal government would be available if the reimbursement rate to providers were raised to 100 percent of actual cost---even in time of fiscal constraint raising reimbursement to levels V and VI would seem to be indicated. Also TDHS should be able to draw down substantially greater training funds under the Title IV-E program.

The Texas Juvenile Probation Commission (TJPC)

There has been very limited development of preventive programs by the juvenile justice system and the challenge grant program which has provided services to a number of youth in selected counties should be expanded. Only one percent of the youth referred to probation departments in 1988 were treated for either mental retardation or emotional disturbance. While administrators estimate that at least 80 percent of the youth referred to TJPC have substance abuse problems, only 25 percent received treatment in 1988. Children less than 10 years of age, at high risk of entering the juvenile justice system, need to be better identified and treatment services should be developed that include both youth and their families. Since 1974, the move has been to deinstitutionalize status offenders such as runaways and truants. Runaways are not longer sheltered by juvenile justice facilities; the burden is transferred to Child Protective Services and the public mental health system, which have experienced shortfalls in funding. With the dramatic increase in children running away from abusive and dysfunctional families, it is important that mechanisms be developed for these children to receive services without having to be labeled delinquent. Improved coordination between TJPC, the schools, TDHS, and the mental health system are clearly required.

Texas Youth Commission (TYC)

There are limited mental health services at TYC due to fiscal restraints and the difficulty in recruiting child psychiatrists. Although in principle TYC will fund severely disturbed youths' placement in residential treatment centers or psychiatric hospitals, if the youths are assaultive or psychotic, appropriate placements are very difficult, if not impossible to obtain. By expanding the Corsicana facility to accommodate 25 such youths, as proposed, TYC could make some progress in this area. Most of the residents at all TYC facilities would benefit from therapeutic, psychological counseling. TYC's current initiatives to expand programs in chemical dependency, less restrictive care as close to home as possible, and to work toward reducing recidivism, are all in the right direction, but they need to be enhanced and coordinated with other agencies.

Other State Agencies

The Texas Commission on Alcohol and Drug Abuse (TCADA), the Job Training Partnership Act (JTPA), and the Texas Rehabilitation Commission (TRC) all treat or provide programs for youth who are, or are at risk of being, seriously emotionally disturbed. All of these programs have substantial funding and would probably be more effective if they more explicitly recognized that a significant percentage of their target populations are likely to have emotional problems that effective treatment or training programs will have to address. The Early Childhood Intervention (ECI) program, administered by the Texas Department of Health, also should be used to provide services to very young children who are at risk of severe emotional disturbance.

State Level Coordination

The Health and Human Services Coordinating Council has provided helpful coordination in developing the cost-based rate system for levels I-VI Residential Contract Care. It also established the Commission on Children, Youth and Family Services. Another encouraging development is the development of a children's mental health plan, with the support of the Mental Health Association in Texas, which is imbedded in the budget requests for the FY 92-93 biennium for TDMHMR, TEA, TYC, TJPC, TDH, TCADA and the ECI Council. Funding this could lead to dramatic improvements in services in Texas (Tables 14.1 and 14.2) It is important that Texas develop the full range of CASSP services within the overall plan.

Private Health Insurance

For many severely emotionally disturbed youth covered by private health insurance there is access to inpatient care until their insurance "runs out." Then they may be "dumped" onto an underfunded public system with little or no capacity to provide in-home or community care. The solution, in part, may be to beef up community-based and intermediate care, which private insurers will also cover, thereby reducing the number of long-term, expensive inpatient stays for which they have to pay. Private insurance contracting with public entities, as CHAMPUS is doing in the Ft. Bragg area with the state of North Carolina, should be examined. In fact private insurers should also work with public programs to jointly fund cases requiring long-term care that is in the best interest of the child and the family.

Expansion of Medicaid

Expansion of Medicaid-covered mental health services, along with mandated changes in the EPSDT program, and childrens' coverage up to age six under the Omnibus Budget Reconciliation Act of 1989, has the potential to provide significant funding for many of the initiatives called for. These services can include case management, comprehensive Early Periodic Screening, Diagnosis and Treatment (EPSDT), clinic or rehabilitation services, school-based clinics, and hospitalization in an institute for mental disease for patients less than 21.

For too long the state legislature has been hesitant to approve optional Medicaid services that have the potential for increasing state costs. This has led to losing millions of dollars in federal Medicaid funds for inpatient and community-based care for children and adolescents. Instead of drawing in badly needed federal funds the state has opted to bear 100 percent of the financial burden for provision of these services. With the recent approval of Medicaid reimbursement of case management for the mentally ill and the likely approval of the rehabilitation services option, this situation is likely to change. However, because the CMHMRCs have not widely served children and adolescents, the impact of the improved provision of mental health services may not reach its full potential.

Medicaid also needs to be utilized when providing services outside of the CMHMRCs. The use of school-based mental health clinics is potentially reimbursable by Medicaid. Serious consideration needs to be given to the establishment of these school-based clinics in Texas as a cornerstone of community-based mental health services for children and adolescents.

The state should also reconsider its reluctance to expand Medicaid to cover inpatient psychiatric hospitalization for those under 21. While this Medicaid option does have the greatest potential of all the optional services for increasing state Medicaid costs, it also has the potential for raising badly needed funds to finance inadequate public inpatient psychiatric care for children and adolescents. The fear of the cost of private-sector participation in this optional Medicaid service has resulted in the lack of inpatient options for poor children and adolescents.

STATE INITIATIVES

These recommendations are made in the context of a great deal of state activity and the recommendations of several commissions which addressed the problems of the severely emotionally disturbed in Texas.

Texas Department of Mental Health and Mental Retardation

One major initiative discussed in Chapter 11 is the $2 million line item for childrens services in the 1990-1991 TDMHMR budget. These funds are being used for demonstration projects for innovative community-based services in four areas in Texas. The projects operated by the CMHMRCs located Austin-Travis County, Sabine Valley, Dallas County, and the Rio Grande State Center. There is also a fifth project which is being jointly funded by TDMHMR and TJPC which will provide community-based mental health services to juvenile offenders with severe emotional disturbance in the Central Counties Community Center catchment area (Hogg Foundation, 1990, p. 21). While these initiatives are limited, they are potentially the building blocks for statewide projects. If these pilot projects are successful in these five sites similar projects may be started in other areas of the state.

Texas Education Agency/Texas Department of Mental Health and Mental Retardation

The TEA/TDMHMR Joint Task Force on Emotional Disturbance made several recommendations regarding criteria that may be used to classify a student as emotionally disturbed. The problem with under-identification of emotional disturbance in the school system was recognized and the task force set a goal to identify a greater number of SED children and adolescents. The task force also recommended continued interagency cooperation in identifying and providing services to SED children and adolescents. This interagency cooperation would be especially helpful in developing programs to deal with children not necessarily covered by PL 94-142 (TEA/TDMHMR, 1988).

Texas Youth Commission/Texas Department of Mental Health and Mental Retardation

TDMHMR and the Texas Youth Commission have been working together in order to more adequately meet the needs of SED youth offenders. The memorandum of understanding (MOU) described in Chapter 6 between these two agencies started out as a pilot project for serving TYC youth in central Texas who suffer from emotional disturbance. This MOU allows for eligible adolescents who have been committed to TYC facilities and programs to be treated in TDMHMR facilities when necessary. The success of this pilot project has spurred TYC and TDMHMR officials to make this program available throughout the state.

Interagency Children's Budget Request

An important initiative taken in the summer of 1990 by the agencies which deal with children is the Texas Children's Mental Health Plan. This plan, spearheaded by the Mental Health Association in Texas, brings together the budgets of several agencies and commissions in order to set aside funds specifically for SED children and adolescents. The Mental Health Association in Texas encouraged TDMHMR, TEA, TYC, TJPC, TDH, TCADA and the ECI Council to prepare coordinated requests for their 1992-1993 biennium budgets which target the needs of SED children and adolescents.

The plan is divided into three packages as shown in Table 14.1. Package I is made up of budget requests from various agencies for community-based core services. These community-based services are comprised of ten components, listed in the table, which will be provided by TDMHMR, TEA, TDHS, TJPC, and TCADA.

Package II focuses on prevention and intervention. TEA would provide parenthood education and TCADA and the ECI Council would provide early childhood intervention services for drug-exposed infants. Five pilot projects would also be set up for school-based health and human services for elementary-school-aged children.

Package III targets emotionally disturbed children and adolescents in the juvenile justice system. TDMHMR and TJPC would work together to provide mental health services to emotionally disturbed juveniles who were in the juvenile court/probation system. This package also includes the construction of a new unit at TYC's facility at Corsicana which will be able to accommodate violent, seriously emotionally disturbed youth. TYC currently must house these youth with other violent offenders at their other facilities that are more secure but may not have the extensive psychological services available that these troubled youth require.

Table 14.2 presents the total costs of the Children's Mental Health Plan for each package and the total costs to the individual agencies involved. The total proposed cost of this plan would be $17 million for FY 1992 and $26 million for FY 1993, making a biennium total of $43 million in additional state funds.

As an adjunct to the plan the agencies have also agreed on a definition of SED youth who are eligible for services. This definition (Appendix 14.1) while excluding a number of SED children with family or private resources will nonetheless help put some accountability and consistency into the system. There is no guarantee that this plan will be approved by the Legislative Budget Board or funded by the legislature. Lacking an initiative of this sort, advocacy groups may decide to file a class action law suite similar to the Willie M. case in North Carolina. This plan identifies a need to place increased emphasis on long-term needs of these children and adolescents in a community-based setting. More community based alternatives need to be constructed, but more importantly there needs to be emphasis placed on the savings to the state in the long term rather than the short-term increase in costs which such a plan will have.

DEVELOPING PROGRAMS AT THE LOCAL LEVEL THAT WORK

While major expansion of programs at the state level is important it is also important that these programs are developed so that they can work to the best interest of children and youth with serious emotional disabilities. Most often the SED child will have multiple problems and will need a continuum of care. This means that the system of care must contain the following very basic elements: The child should be treated in the least restrictive environment as close to home as possible. Whenever possible, the child's family should be included in the child's treatment plan. Unless there are indications to the contrary, the child's family must be viewed as allies and advocates. The treatment plan should be provided in a culturally sensitive manner, and care must be taken to equalize the availability of treatment to all races and ethnic groups. The child should have a treatment plan that integrates all of the elements, services, and agencies that will be necessary to his/her care. The child's treatment plan must be a plan that individualizes treatment for the child. The Texas Education Agency and, wherever appropriate, the public schools should be an active participant in the child's treatment plan. And finally, adequate levels of funding must be provided.

Table 14.1. Texas Children's Mental Health Plan Proposed Budget for FY 1992-1993 Biennium

Package I. Community-Based Core Services to Seriously Emotionally Disturbed Children

Core Service	FY 1992	FY 1993
1. Assesment Services		
TDMHMR	$ 385,000	$ 979,000
2. Medication-Related Services		
TDMHMR	$ 490,000	$1,246,000
3. Crisis Resolution Services		
TDMHMR	$ 450,000	$1,094,700
4. Community-Based Residential Beds		
TDMHMR	$ 869,000	$2,225,000
5. Day Treatment		
TEA	$1,000,000	$2,000,000
TDMHMR	$1,000,000	$2,000,000
- School-Related Family Support Services		
- 5,000 Children at 15 sites (joint implementation)		
6. Family Services		
TDMHMR	$ 196,000	$ 504,400
7. Therapeutic Foster and Group Care		
TDHS	$ 894,000	$2,589,000
TDMHMR	$ 606,935	$1,337,705
TJPC	$ 606,935	$1,337,705
8. Substance Abuse Treatment		
TCADA	$ 876,000	$ 876,000
9. Case Management		
TDMHMR	$ 980,000	$2,492,000
TDHS	in-kind	in-kind
TYC	in-kind	in-kind
TJPC	in-kind	in-kind
10. Psychosocial Rehabilitation Services		
TDMHMR	$ 128,500	$ 358,900

(Continued Next Page)

Table 14.1 (Continued) Texas Children's Mental Health Plan Proposed Budget for FY 1992-1993 Biennium

Package II. Prevention and Early Intervention

1. Parenthood Education

15 Programs @ $50,000 each; approximately 80 families per program. School districts with a high ratio of at-risk families will be targeted.

	FY 1992	FY 1993
TEA	$ 750,000	$ 750,000

2. Early Childhood Intervention: Drug Exposed Infants

Coordinated drug treatment for mothers (TCADA) and specialized early childhood intervention services for drug-exposed children ages 0-3 (ECI).

		FY 1992	FY 1993
2 sites	TCADA	$1,000,000	$1,500,000
	ECI Council	$ 75,000	$ 75,000

Specialized early childhood intervention for drug-exposed babies 0-3 in foster care (ECI) with long-term evaluation and follow-up (TCADA)

		FY 1992	FY 1993
1 site	ECI Council	$ 150,000	$ 150,000
	TCADA		$ 50,000

3. School-Based Health and Human Services for Elementary School-Aged Children

	FY 1992	FY 1993
Five Pilot Projects to Include:		
- Physical Facilities	In-Kind	In-Kind
- Program Coordination (TEA)	$ 174,250	$ 191,675
- Student Assistance Teams (TEA)	$ 150,000	$ 165,000
- Health Clinic (TDH)	$ 105,205	$ 105,205
- Counseling (TDMHMR)	$ 250,000	$ 250,000
- Substance Abuse Education and Early Identification (TEA)	$ 150,000	$ 150,000
- Substance Abuse Counseling and Intervention (TCADA)	$ 500,000	$ 500,000
- Drop-Out Prevention	In-Kind	In-Kind
- Abuse and Neglect Intervention (TDHS)	In-Kind	In-Kind

(Continued Next Page)

Table 14.1 (Continued) Texas Children's Mental Health Plan Proposed Budget for FY 1992-1993 Biennium

Package III. Specialized Services to Emotionally Disturbed Children In the Juvenile Justice System

1. Community Mental Health Care to Juveniles Referred to Juvenile Court (Expansion of TJPC/TDMHMR Initiative)

Continuation of Current Site	FY 1992	FY 1993
TDMHMR	$ 250,000	$ 250,000
TJPC	$ 250,000	$ 250,000

Five Additional Sites	FY 1992	FY 1993
TDMHMR	$ 500,000	$1,250,000
TJPC	$ 500,000	$1,250,000

2. Services to Violent, Seriously Emotionally Disturbed Youth

Construction of a New Facility at Corsicana	FY 1992	FY 1993
TYC	$2,085,019	

Source: MHAT, 1990, pp. 1, 4, 7.

Table 14.2. Total Costs of the Texas Children's Mental Health Plan Proposed Budget for FY 1992-1993 Biennium

PACKAGE I

Agency	FY 1992	FY 1993
TDMHMR		
14 Demonstration Sites	$ 3,500,000	$ 8,900,000
Family Support, Foster Care $ 606,935	$ 3,337,705	
31 Mini-Grants (Planning)	$ 1,550,000	
Administration	$ 100,144	$ 125,176
TDMHMR Total	$ 6,757,079	$12,362,881
TEA	$ 1,000,000	$ 2,000,000
TCADA	$ 876,000	$ 876,000
TJPC	$ 606,935	$ 1,337,705
TDHS	$ 852,000	$ 2,365,000
TYC		# not yet available
Total Package I	**$10,134,014**	**$19,165,586**

PACKAGE II

Agency	FY 1992	FY 1993
TEA	$ 1,224,250	$ 1,256,575
TCADA	$ 1,500,000	$ 2,050,000
TDMHMR	$ 250,000	$ 250,000
TDH	$ 105,205	$ 105,205
ECI Council	$ 225,000	$ 225,000
Total Package II	**$ 3,304,455**	**$ 3,886,780**

PACKAGE III

Agency	FY 1992	FY 1993
TJPC	$ 750,000	$ 1,500,000
TDMHMR	$ 750,000	$ 1,500,000
TYC	$ 2,085,019	
Total Package III	**$ 3,585,019**	**$ 3,000,000**
TOTAL PACKAGES I, II, & III	**$17,023,488**	**$26,052,366**
BIENNIUM TOTAL		**$43,075,854**

Source: MHAT, 1990, p. 8.

A number of factors have constrained the development of an effective SED care delivery system in Texas. Until recently no meaningful definition has been developed as to what constitutes a SED youth that all agencies can agree upon and follow (see appendix 14.1). There is inadequate public awareness of the depth and scope of the problem of SED youth, and how ultimately all are affected by not addressing the problem. Effective advocacy for children in general and SED children in particular has been missing. SED children and adolescents are under-identified. The totally inconsistent boundary system between state agencies and between state agencies and the schools and the lack of effective coordination between agencies at the local level as well as overlapping regional boundaries for state and local agencies have all led to a balkanized system. The lack of awareness even on the part of many health care professionals as to existing services and how to access them remains a problem. Even when services are available many children in need are ineligibile. The lack of longitudinal studies to show which programs are most effective and inadequate funding at all levels, uncoordinated funding mechanisms and the shortage of child psychiatrists have all combined to produce a very inadequate system.

All of these factors combined together present a formidable obstacle. However, initiatives by MHAT, TDMHMR, TEA, TYC, TJPC, the Hogg Foundation, and others represent a positive move towards a comprehensive continuum of care for SED children and adolescents in Texas.

The one initiative which has done a great deal to bring attention to SED children and adolescents and the problems in the provision of services is CASSP. The CASSP program that has been in existence in Texas since the fall of 1988 has made inroads into many of the areas discussed above. The program is aiding Texas in developing an appropriate continuum of care for SED youth. CASSP focuses on a comprehensive, broad-based policy and has worked with local demonstration projects that could form the basis for a state program. It has provided funding to start parent advocacy groups and has included parents in the planning for their children. It also provides technical assistance and training for the parents of SED youth. CASSP in Texas has taken a comparatively small amount of federal funding, used it effectively, and spread it a very long way. The program has shown its efficacy and deserves continuation.

FUNDING

In the state of Texas, the funding problem is quite simply that there is wholly inadequate funding at every level for the identification and rehabilitation of SED children. Texas is forty-eighth in the country in spending on mental health, and very little of Texas' public health dollar goes to children (Torrey, Wolfe, and Flynn, 1988). The possible levels of public funding are local, state, federal, and private contributors. There is also a source of private funding through private insurance.

Local funds are used for two primary purposes that affect SED youth, the schools and the juvenile justice system, especially juvenile probation (TJPC). State funds are used primarily for state agencies who care of SED youth (TDMHMR, TDHS, and TRC), agencies involved in drug or alcohol rehabilitation (TCADA), and the juvenile justice system, especially juvenile institutionalization (TYC). Federal funds are used primarily as an adjunct to state and local funds in the areas just discussed, in the development of the CASSP program, and for job training (JTPA). Private insurance is used in accordance with the way the plan is set up, and much too often that means that it will be used for the most restrictive care -- the most costly method of care and a method that is of unproven cost effectiveness.

Where Texas is Today in Its Efforts to Fund

With its present tax structures the state of Texas is very limited in its ability to fund these services, and because they have already had to pick up the slack from state funding, local governments are very limited in their ability to fund. There are federal funds available through Medicaid, PL 94-142, and IV-e that the state has not drawn upon. However, the use of any of these federal funds requires a state match. Although as detailed above, there are mechanisms by which current expenditures by state and local entities can be matched, the details have not been worked out.

In mental health it is true to say that services follow the dollar. There is no need to worry about coordinating services if funding of the services is lacking. Assuming that funding exists, it needs to be targeted. If whatever funding exists is spread too thin, in the end fewer patients are helped in any significant way. Funding can be targeted to those most in need, for example, young children or for broad community-based care.

There are various ways that funding can proceed, and which way will be most effective will depend in part on the state plan that emerges. In all cases the budget plan should be set up in such a way that the ability to receive matching federal funds is maximized. Three possibilities are

1. have a sum of money that follows the child. Each agency that serves the child would draw from this sum, and the accounting records would provide a record of services.
2. give each agency a budget. However, there is a need to cut some agency strings and to give the agency some flexibility.
3. have a composite budget for the care of SED youth that each agency draws upon as needed.

Whatever budgeting system is adopted, it needs to contain incentives for an agency to move children up through the levels of care and to sign off on a child when treatment is completed. Current funding practices contain some disincentives to do either of these.

Part of the strain on the public dollar could be reduced if group plans for private insurance could work cooperatively with public providers and to arrange for intermediate care services. This will only occur if public programs are effective and of high quality. With family support systems weakening for many in society, development of these services and programs for the adults of tomorrow has become of highest priority.

Appendix 14.1. Target Population Definition for Children with Serious Emotional Disturbance of the Interagency Children's Mental Health Initiative

Must have (I, II, and III) or (I, II, and IV) or V.

I. Diagnosis
DSM-III R Axis I or II diagnosis, except a single diagnosis of psychoactive substance use disorder, developmental disorder, or V code. Organic mental disorders are included only while behaviors are a danger to self or others.

II. Risk of Separation from Family
Risk of or separation from family due to, for example: (1) chronic family dysfunction involving mentally ill and/or inadequate caretaker, or multiple agency contacts, or changes in custodial adult; or (2) going to, residing in, returning from any out-of-home placement, e.g., psychiatric hospital, short-term inpatient , residential treatment, group or foster home, corrections facility, etc.

III. Functional Impairments/Symptoms
Must have A or B:

A. Functional impairment. Must have substantial impairment in two of the following capacities to function (corresponding to expected developmental level):
1. Autonomous functioning.
2. Functioning in the community.
3. Functioning in the family or family equivalent.
4. Functioning in school/work.

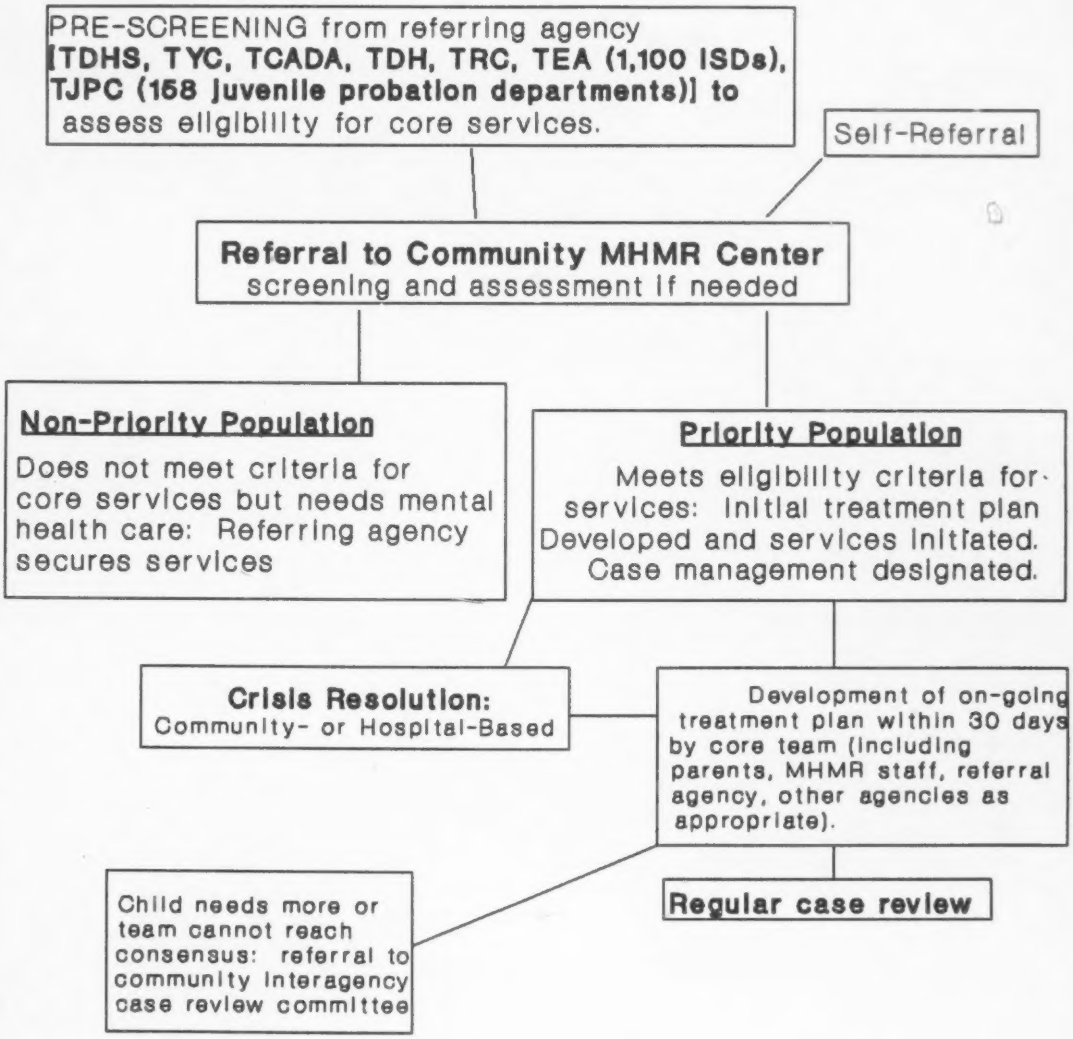
B. Symptoms. Must have one of the following:
1. Psychotic symptoms
2. Suicidal risk.
3. Violence: At risk of causing injury to person of significant damage to property, due to mental illness.

IV. History
Without treatment, there is imminent risk of decompensation or separation from family in Section II above.

V. Special Education Students
Special education students who have been assessed as being seriously emotionally disturbed and have identified mental health needs in their individualized education plans.

Source: MHAT, 1990, p. 12.

Appendix 14.2. Service Delivery Plan for Core Service to Children with Serious Emotional Disturbance


PRE-SCREENING from referring agency [TDHS, TYC, TCADA, TDH, TRC, TEA (1,100 ISDs), TJPC (158 juvenile probation departments)] to assess eligibility for core services.
Self-Referral
Referral to Community MHMR Center screening and assessment if needed
Non-Priority Population
Does not meet criteria for core services but needs mental health care: Referring agency secures services
Priority Population
Meets eligibility criteria for services: Initial treatment plan Developed and services initiated. Case management designated.
Crisis Resolution: Community- or Hospital-Based
Development of on-going treatment plan within 30 days by core team (including parents, MHMR staff, referral agency, other agencies as appropriate).
Regular case review
Child needs more or team cannot reach consensus: referral to community interagency case review committee

Source: MHAT, 1990, p. 13.

References

Mental Health Association in Texas (MHAT). 1989. Do Kids Count? Austin, Texas.

____________. 1990. "Texas Children's Mental Health Plan." Austin, Texas (September 17).

Hogg Foundation for Mental Health. 1990. Children and Youth with Severe Emotional Disturbance - The Problem for Texas. Task Force on Children and Adolescents with Severe Emotional Disturbance. Austin, Texas.

Texas Education Agency (TEA). 1988. Report of the Texas Education Agency/Texas Department of Mental Health and Mental Retardation Joint Task Force on Emotional Disturbance. Austin, Texas.

Torrey, E. Fuller, Sidney M. Wolfe, and Laurie M. Flynn. 1988. Care of the Seriously Mentally Ill: A Rating of State Programs. 2nd ed. Washington, D.C.: Public Citizen Health Research Group and the National Alliance for the Mentally Ill.

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